Exploring Menopause Through a Cultural Lens:
Beliefs, Perceptions, and Experiences of Immigrant Punjabi Women in the Peel Region

by

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

Background: Menopause, despite being a pivotal stage in a woman's life, is not a uniform experience. For immigrant Punjabi women, it is shaped by challenges influenced by their socio-cultural backgrounds, beliefs and social norms (Zou et al., 2023). In addition to the complexities introduced by migration, language barriers, social marginalization, and a lack of culturally relevant healthcare services often contribute to unmet needs of immigrant Punjabi women. While existing literature highlights how menopause is shaped by cultural and social factors, the experiences of South Asian immigrant women – particularly Punjabi women in Canada – remain unexplored. This study seeks to address this gap by exploring the beliefs, perceptions, and lived experiences of menopause among immigrant Punjabi women in the Peel Region, with the goal of informing how cultural humility and tailored healthcare approaches can enhance menopausal care for this population.

Research Questions: What are the beliefs and perceptions of immigrant Punjabi women in the Peel Region regarding menopause, and how do these shape their lived experiences of this transition? How do cultural practices, social norms, and immigration experiences influence the perceptions and management of menopause? What insights from their experiences can inform culturally responsive practices to better address their needs?

Methods: This qualitative study employed a Constructivist Grounded Theory (CGT) methodology to explore the experiences of menopause among immigrant Punjabi women aged 35 and older who have lived in the Peel Region for at least five years. Thirteen semi-structured interviews were conducted in either English or Punjabi, depending on participant preference, to ensure linguistic and cultural comfort. Interviews were audio-recorded, transcribed, and translated by the researcher to preserve cultural nuance. Data were analyzed inductively through the CGT process of initial coding, focused coding, and axial coding, allowing themes, and analytical categories, to emerge from participants' narratives. Reflexivity and attention to positionality were prioritized throughout, recognizing the co-constructed nature of meaning between the researcher and participants.

Findings: Three interconnected core themes emerged from the data: (1) Silenced and Stigmatized: Cultural Taboos and Lack of Menopause Education, (2) Navigating Menopause in Isolation: Gender Roles, Migration, and Social Expectations, and (3) Seeking Support and Self-Advocacy: Pathways to Empowerment and Care. Participants described menopause as a topic shrouded in silence, often associated with shame and misinformation in their upbringing. Many women felt unprepared and

unsupported, facing the transition in isolation while juggling familial responsibilities, caregiving roles, and the pressures of migration. However, some participants emphasized the importance of informal peer networks and expressed a desire for culturally safe, linguistically appropriate, and holistic care. These narratives reflected a tension between traditional cultural expectations and the evolving understanding of health and aging in a new socio-cultural context.

Conclusions: This study provides an in-depth, intersectional understanding of how immigrant Punjabi women experience menopause within the complex contexts of culture, gender, and migration. The findings underscore the urgent need for culturally responsive healthcare services that acknowledge the social realities and cultural frameworks of immigrant communities. By promoting cultural humility among healthcare providers and engaging in community-informed education initiatives, it is possible to reduce stigma, improve early intervention, and support immigrant women in navigating menopause with dignity and agency. This research contributes to the broader discourse on reproductive aging and equity in healthcare by centering the voices of a marginalized population whose experiences have been largely overlooked.

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Dedication

To my parents, who left their home, their family, their friends, their social circles, and life as they knew it, to pursue greater opportunities and success in Canada. Thank you for teaching me the power of education, and for always pushing me to achieve more. Your sacrifices are the foundation of everything I do. Most importantly, thank you for never letting me be afraid of celebrating our religion, culture and roots. That pride positioned me in such a way that pursuing this study became more than an academic endeavor – it became an act of contributing to the growth and empowerment of our community.

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List of Abbreviations

CAHSPR	The Canadian Association of Health Services and Policy Research
CGT	Constructivist Grounded Theory
ECE	Early Childhood Education
GTA	Greater Toronto Area
LOI	Letter of Information
ORE	Office of Research Ethics
REB	Research Ethics Board
WHO	World Health Organization

Chapter 1
Background and Literature Review

1.1 Experiences of Menopause among Immigrant Women

Menopause, despite being a pivotal stage in a woman's life, is not a uniform experience; for immigrant South Asian women, it is profoundly shaped by unique challenges influenced by their socio-cultural backgrounds, beliefs and social norms (Zou et al., 2023). Literature suggests that these factors directly contribute to a plethora of challenges experienced during this midlife transition period for women (Zou et al., 2023). For immigrant South Asian women, including Punjabi women in Canada, the shift to a new cultural and healthcare environment, with migration and immigration, may open avenues to reassess previously held beliefs about menopause – presenting opportunities for women to adopt different viewpoints and ways of thinking about these health transitions (Zou et al., 2023). Menopause, a natural biological process and commonly cited 'universal experience', marks the end of a woman's reproductive potential; this transition contributes to the etiology of symptoms such as hot flashes, night sweats, mood changes and sleep disturbances (Sherman, 2005). As Zou et al. (2023) suggest, menopausal experiences are deeply intertwined with the cultural and social challenges that come with immigration – including social marginalization – and can expose women to experience disparities in the system. This may encourage women to reinterpret their symptoms and navigate menopause in a way that reflects both their traditional cultural understandings and new perspectives influenced by the Canadian healthcare system. This dual influence could directly impact how these women interpret and seek support for menopausal symptoms that need medical attention, which may expose them to challenges and disparities within the healthcare system, including social marginalization (Zou et al., 2021).

Migrant women, while often relying on self-care strategies rooted in their cultural practices, may be reluctant to seek healthcare services for menopause, even when they experience symptoms that necessitate professional care (Stanzel et al., 2021). When they do access menopause-related healthcare services, the care is often perceived as inadequate, leading to reluctance in seeking future support (Stanzel et al., 2021). A 'healthy menopause' framework, developed by Jaspers and colleagues (2015), proposes that menopause-related care should be able to support women in self-managing their health, promoting physical, psychological, and social well-being. Using this framework, along with the understanding that immigrant women should have access to care models that adopt cultural humility practices, to better navigate menopause, can help enhance their immediate

and long-term health. However, Shaw and colleagues propose that the low use and uptake of health screening and preventive healthcare services among immigrants can be explained by the differences in perceptions of illness etiology, diagnosis, and appropriate treatment and care (Shaw et al., 2008). Recent studies have highlighted the importance of cultural and social contexts in shaping menopausal experiences among immigrant women. For instance, research by Griffiths et al. (2022) found that immigrant women often face challenges in communicating their menopausal symptoms due to cultural taboos, language barriers, and a lack of cultural humility in healthcare services. Similarly, Zanchetta et al. (2020) emphasized the role of cultural health beliefs in influencing how immigrant women perceive menopause, often prioritizing traditional self-care practices over seeking formal medical advice. A systematic review by Hamiduzzaman et al. (2021) further noted that immigrant women are less likely to seek medical intervention for menopause-related issues due to mistrust in healthcare systems, lack of cultural humility in care, and the influence of familial and community expectations.

1.2 The Importance of Cultural Humility

Cultural humility is increasingly recognized as a critical framework in healthcare, particularly for addressing the needs of diverse and immigrant populations. It has been proposed as a replacement for earlier constructs such as cultural competence, cultural sensitivity, cultural safety, and cultural respect (Lekas et al., 2020). Unlike these earlier models, which often imply that culture can be fully understood or mastered, cultural humility emphasizes that culture is dynamic, fluid, and shaped by ongoing interactions with institutions, media, technology, and broader social determinants of health (Lekas et al., 2020).

The concept challenges the notion that one can be fully competent or sensitive in relation to another's culture, which risks reinforcing stereotypes and assumptions of homogeneity within cultural groups (Lekas et al., 2020). Instead, cultural humility promotes a lifelong process of self-reflection, critical self-evaluation, and openness to learning from patients about their lived realities (Lekas et al., 2020). This approach supports the development of person-centered, power-balanced relationships between providers and patients, ultimately enhancing the quality of care for immigrant populations (Lekas et al., 2020). In the context of menopause, cultural humility becomes especially important. Language barriers, the absence of culturally relevant care, and a lack of culturally responsive communication can result in social isolation and reduced confidence in navigating healthcare systems

(Grewal et al., 2005). Immigrant women may also experience limited access to information and support, which can compound the challenges of the menopausal transition (Grewal et al., 2005). Thus, embedding cultural humility into healthcare delivery and social support systems can help to mitigate these barriers and ensure that care is attuned to the diverse experiences and needs of immigrant women (Santoro et al., 2020).

Cultural humility is especially vital when working with South Asian populations, whose healthcare needs and cultural perspectives differ significantly from other populations (Krishnan et al., 2023). Cultural humility serves as a guiding framework to promote patient-centered care through openness, critical self-reflection, and a willingness to learn from patients themselves (Krishnan et al., 2023). It moves beyond assumptions of cultural competence and acknowledges that healthcare providers cannot fully understand a patient's cultural experience better than the patient can – if they are from different cultural backgrounds (Krishnan et al., 2023). It remains essential that providers understand how cultural norms, gender roles, intergenerational expectations, and stigma around topics, such as menopause, may affect clinical decision-making and health-seeking behaviours within South Asian communities, such as the Punjabi community (Krishnan et al., 2023). In multicultural societies where power imbalances are embedded in healthcare systems, practicing cultural humility fosters mutual respect, partnership, and lifelong learning (Krishnan et al., 2023). For South Asian women, who often navigate layered barriers including patriarchal expectations, language challenges, and culturally ingrained silence around reproductive health, culturally humble care can improve their healthcare experiences and outcomes (Grewal et al., 2005).

1.3 Intersectionality and the Healthy Menopause Framework

In addition to these social and cultural influences, there is a growing recognition of the intersectionality of immigrant women's experiences, especially regarding health (Hankivsky & Cormier, 2009). Intersectionality, a term popularized by Kimberlé Crenshaw, originally described the overlapping and interdependent systems of oppression that affect Black women, focusing on how race and gender interact to create unique forms of discrimination (Davis, 2008). Crenshaw's framework has since expanded to encompass other systems of oppression, such as class, immigration status, sexual orientation, and ethnicity (Carbado et al., 2013). It highlights how the compounding of multiple marginalized identities can intensify barriers to care and shape lived experiences in distinct ways (Davis, 2008).

For immigrant Punjabi women, intersectionality offers a valuable lens to understand how gender, age, ethnicity, and status as immigrants intersect to shape their unique experiences of menopause (Koehn, 2021). This includes navigating cultural stigmas and taboos surrounding aging and health, while also encountering structural barriers such as language access, limited culturally relevant resources, and systemic bias within the Canadian healthcare system. These overlapping factors may result in diminished access to support, underdiagnosis of symptoms, and unmet needs in care delivery. To further contextualize these experiences, this study draws on the Healthy Menopause Framework developed by Jaspers and colleagues (2015), which emphasizes a holistic understanding of menopause encompassing biological, psychological, sociocultural, and behavioural dimensions. This framework encourages the consideration of how social determinants and cultural perceptions shape women's menopausal transitions. Importantly, it aligns with the values of cultural humility, reinforcing the needs for a care model that adapts to women's lived experiences, rather than expecting them to conform to a standardized model of care (Jaspers et al., 2015).

By combining the lens of intersectionality with the Healthy Menopause Framework, this study explored the ways in which culturally humble, person-centered care can address the unique and complex needs of immigrant Punjabi women during menopause. It sought to contribute to a deeper understanding of how layered identities and power dynamics shape access to care, experience of symptoms, and perceptions of wellness (Davis, 2008) – which fills a critical gap in the literature on immigrant women's health in Canada.

1.4 South Asian Immigrants in Canada

Among immigrant populations in Canada, individuals of South Asian descent constitute a significant demographic subgroup. By the year 2041, the South Asian population in Canada is expected to exceed a total of 5 million individuals (Statistics Canada, 2023). These projections stem from the 2021 Census which showed that approximately 7 million individuals reported origins from Asia, representing 19.3% of the total Canadian population (Statistics Canada, 2023). South Asians were reported as the largest visible minority in Canada, among which 44.3%, 9.2%, 5.4% and 3% were born in South Asian countries: India, Pakistan, Sri Lanka and Bangladesh, respectively (The Canadian Encyclopedia, 2023). As Canada continues to welcome and attract immigrants from South Asian countries, it is important to understand the experiences and challenges encountered by this

population in navigating the Canadian healthcare system to ensure equitable and effective healthcare delivery.

Immigration being noted as a major driver of population growth in Canada and changing trends in immigration have shifted demographic characteristics – which are now constantly evolving (Statistics Canada, 2016). With a growing female population, Statistics Canada's 2031 projections show that of the estimated 11.1 million immigrants, 5.8 million (or 52.3%) would be women and girls, which would then represent 27.4% of Canada's total female population (Statistics Canada, 2016). India is one of the top three reported countries of birth for immigrants in Canada (Statistics Canada, 2016). Additionally, the majority of immigrant women report belonging to a visible minority group (Statistics Canada, 2016). As a result, South Asian female immigrants make up a significant proportion of the immigrant population in Canada (Statistics Canada, 2016). These immigrants tend to settle mostly in the top four most populated Canadian provinces – Ontario, Quebec, British Columbia and Alberta, and within these provinces, there is a relatively high proportion of immigrants residing in large metropolitan areas and surrounding municipalities (Statistics Canada, 2016). Punjabi was consistently reported as being one of the most commonly spoken languages by female immigrants, nationally (Statistics Canada, 2016).

1.5 Punjabi People and Punjabi Culture

The Punjabi people trace their origins to the agriculturally rich Punjab region, also known as 'the Land of Five Rivers', historically part of the Indian subcontinent and now divided between India and Pakistan since the 1947 Partition (Bhardwaj & Sharma, 2024). According to the most recent Population census in India, majority of the population in Punjab reported belonging to the Sikh faith (Population Census, 2011). The 15th-century emergence of Sikhism, founded by Guru Nanak, introduced a unique religious and social ethos, emphasizing community service, equality, and resilience, which has since become integral to Punjabi identity (Ahluwalia & Camardella, 2019). Punjabi culture is marked by close family bonds, collective decision-making, and support networks that often prioritize familial and community guidance (Iqbal, 2022). Strongly influenced by traditional values, Punjabi families maintain customs that stress respect for elders, community cohesion, and adherence to cultural norms, which shape their approach to health, well-being, and life transitions (Iqbal, 2022). As Punjabi communities have migrated globally, especially to countries like Canada, they bring these deep-rooted traditions with them, adapting them within new cultural

frameworks while preserving core values (Iqbal, 2022). These cultural elements shape how immigrant Punjabi women approach significant life transitions, like menopause, and influence their engagement within the healthcare systems (Zou et al., 2021). Accustomed to relying on traditional self-care methods and informal support networks, they often face challenges navigating healthcare models in the Global North, where their unique cultural needs and expectations may not always be met (Swihart et al., 2024). Consequently, for healthcare providers and policy makers, understanding Punjabi culture is essential to improving healthcare experiences and access to healthcare services for immigrant Punjabi women, ensuring cultural humility that recognizes and honors their heritage.

Indian culture, as a direct influence on, Punjabi culture, places a strong emphasis on familial structures, traditional gender roles, and community cohesion – values that often inform how health is perceived and managed (Chadda & Deb, 2013). Punjabi women may prioritize traditional health practices and rely heavily on informal lay social and support networks, such as family and community elders, rather than accessing formal healthcare systems (Chiu et al., 2005). This cultural context shapes their experience of menopause, often characterized by silence (Dhillon & Humble, 2021) due to cultural taboos around aging and reproductive health (Biondo et al., 2017). In many South Asian communities, including Punjabi, discussing menopause openly can be stigmatized, leading to underreporting of symptoms and reluctance to seek medical care (Biondo et al., 2017). Cultural and religious beliefs, values, norms, and superstitions all combine to contribute to the overall reluctance experienced by these women when it comes to engaging in discussions relevant to their healthcare (Biondo et al., 2017). While they may seek relief through self-care strategies based on traditional practices, they often encounter difficulties when navigating the Canadian healthcare system, finding it to be inadequate or insensitive to their cultural needs (Stanzel et al., 2021). This is compounded by their status as immigrants, which introduces additional layers of marginalization, including social isolation and limited access to culturally relevant healthcare services. The concept of self-care, as used in this context, refers to a broad set of practices and behaviours that individuals engage in maintain and enhance their physical, mental, and emotional well-being (Martinez et al., 2021). The concept of self-care, in this context, is further augmented by the gender-based role of women in South Asian families (Ahmad, 2002).

1.6 The Menopause Transition

While all women experience menopause, not all require healthcare services to manage it; this transition varies widely in its impact (Aninye et al., 2021). For some, menopause brings severe symptoms that create a need for medical intervention, especially when these symptoms significantly affect daily life. For immigrant Punjabi women, this need may be compounded by challenges linked to cultural norms, language barriers, and social marginalization, which together can create a vulnerable position for those needing but unable to access healthcare. Studies indicate that immigrant women often resort to self-care strategies and traditional healing methods rooted in their cultural practices, varying from home remedies using herbs to consultations with homeopaths, veds[1], babajis[2] and more[3] (Hilton et al., 2001). However, these studies also further indicate that when formal healthcare is sought, immigrant women frequently encounter care that lacks cultural humility or fails to meet their expectations (Stanzel et al., 2021). Thus, while healthcare access may not be necessary for all, ensuring it is available and tailored for those who need it is critical for equitable menopausal care. Given the diverse ways in which women experience menopause, it is essential to recognize that healthcare services should be responsive to the diversity of symptoms rather than assuming a one-size-fits-all need for women.

For immigrant Punjabi women, who may face additional barriers due to cultural expectations and the complexities of adapting to a new healthcare system, access to appropriate care can be especially challenging. Cultural stigmas around aging and reproductive health often discourage open discussions about menopause, leading many women to rely on informal networks for advice (Chiu et al., 2005). These networks, while supportive, may not always provide accurate or comprehensive health information, which can hinder timely medical intervention for those experiencing severe symptoms (Chiu et al., 2005). Furthermore, language barriers, a lack of cultural humility and a lack of culturally relevant healthcare options can exacerbate feelings of isolation and reduce confidence in seeking care (Grewal et al., 2005).

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[1] Veds are practitioners of Ayurveda, a traditional Indian system of medicine based on balancing bodily energies through diet, herbal treatments, and yogic breathing (Venkatasalu, 2011).
[2] Babajis are spiritual or religious figures, often sought for guidance, prayers, or ritual-based healing (Venkatasalu, 2011).
[3] Other healers such as homeopaths, hakims (practitioners of Unani medicine), and jyotshis (astrologers) may also provide culturally rooted health advice and treatment, particularly for issues believed to be connected to karma, the evil eye, or spiritual imbalance (Venkatasalu, 2011).

Moreover, research has shown that immigrant women's health-seeking behaviors during menopause are influenced by their integration into the host society (Kirchengast, 2024). As Choudhry (2001) and Grewal et al. (2005) found, women who experienced greater social isolation due to migration were more likely to rely on informal networks for health advice, further complicating their access to appropriate medical care. These informal networks include social connections and relationships within personal networks – including family members and friends (Stick et al., 2024). These findings point to the necessity of addressing both cultural humility in healthcare provision and the social support structures that immigrant women navigate during midlife transitions – including the disruptive menopausal transition (Santoro et al., 2020). By focusing on the unique cultural and social factors impacting South Asian Punjabi women in Canada, this research will contribute to the growing body of literature that seeks to improve healthcare access and experiences for immigrant populations.

1.7 Research Gaps

Previous studies, notably one published by Theresa George in 1988, examined the menopausal experiences of Sikh women in Vancouver, British Columbia (George, 1988). Findings revealed that participants generally viewed menopause as a positive life transition – describing it as a 'cleansing' experience with relief from the perceived impurity of menstruation (George, 1988). Women in both pre- and post-menopausal stages expressed little fear or concern, framing menopause as a natural, fulfilling milestone, especially after having completed their familial and reproductive duties (George, 1988). George noted that these attitudes were shaped by deeply embedded cultural beliefs surrounding menstruation, aging, and womanhood, despite the absence of such notions in the Sikh religion. However, in addition to being over three decades old, this study is limited in scope. It focused solely on Sikh women in Vancouver and excluding childless women or those with differing life circumstances. It also does not capture the evolving experiences of South Asian women in other parts of Canada - particularly Ontario, which now has one of the largest South Asian immigrant populations in the country (Zou et al., 2023). As such, there remains a need for updated and regionally relevant research that reflects the diverse realities of immigrant Punjabi women navigating menopause today.

Much of the existing research on menopause focuses on and greatly emphasizes the biological aspects of menopause, rather than emotional and mental experiences, which are deeply intertwined with cultural and social challenges (Zou et al., 2021). Since Geroge's study, shifts in

immigration policies, healthcare access, and community resources have significantly altered the landscape of support available to immigrant women – which in turn, shapes their menopausal experiences (Zou et al., 2023). These changes further underscore the importance of contemporary, culturally grounded research that centers the voices of immigrant Punjabi women in a region with a large demographic of Punjabi immigrants (Statistics Canada, 2016).

Chapter 2
Aims, Study Objectives and Research Questions

2.1 Aims

The specific aims of this thesis were to explore the menopausal experiences of Punjabi women and understand the sociocultural factors that shaped these experiences. Through this research, I sought to address the following:

a) Investigate Punjabi women's experiences, thoughts, or perceptions of menopause and reproductive health trajectories: this aim focuses on capturing the lived experiences of menopause among Punjabi women, mapping out the stages of their reproductive health journey and how they manage the physical, emotional, and social aspects of menopause.

b) Explore the cultural beliefs, traditions, and intergenerational attitudes within the Punjabi community that shape how menopause is perceived and experienced by women: this aim attempts to understand how cultural and familial factors influence women's conceptualization and emotional responses to menopause.

c) Examine the social and systemic factors, including family roles, community dynamics, and access to healthcare, that affect how Punjabi women understand or manage menopausal symptoms and seek support or treatment: this aim will investigate external and systemic influences on health-seeking behaviours and the barriers faced in accessing menopause-related care.

By conducting this study, I aimed to contribute to the literature on immigrant women's reproductive health, particularly within the Punjabi community. This research addressed a critical gap by exploring the menopause experiences of Punjabi immigrant women, a group that remains underrepresented in reproductive health studies. While much research has focused on menopause in general, there is limited understanding of how cultural, social, and migration-related factors shape the experiences of South Asian women in the context of menopause (Zou et al., 2023). By uncovering these experiences and highlighting the unique challenges faced by this community, the study offered valuable insights into how sociocultural beliefs influenced health-seeking behaviors, menopause management, and overall well-being. This contribution was significant, as it will inform healthcare providers and policymakers on the need for care embedded in cultural humility, tailored to the

specific needs of immigrant women, thereby enhancing health outcomes for marginalized populations. In doing so, I aimed to ignite conversations on reproductive health within the Punjabi and South Asian communities, fostering awareness, promoting the 'healthy menopause' framework (Jaspers et al., 2015), and challenging stigma related to menopause.

2.2 Study Objectives

Exploring the menopausal experiences of Punjabi women in Canada is critical for several reasons. As one of the largest racialized groups in Canada, the healthcare needs of this community cannot be overlooked. The intersection of cultural beliefs, immigration-related stressors, and systemic healthcare barriers creates a unique set of challenges for Punjabi women during menopause. By studying these experiences, we can better understand how cultural norms and immigrant status shape health outcomes and identify gaps in healthcare provision that could be addressed through interventions rooted in cultural humility. My research aims to address this gap by examining the experiences of menopause and reproductive health trajectories among Immigrant Punjabi women in the Peel Region. Specifically, I aim to (a) investigate Punjabi women's experiences, thoughts[4], or perceptions[5] of menopause and reproductive health trajectories[6], (b) explore the cultural beliefs, traditions, and intergenerational attitudes within the Punjabi community that shape how menopause is perceived and experienced by women, and (c) examine social and systemic factors, including family roles, community dynamics, and access to healthcare, that affect how Punjabi women understand or manage menopausal symptoms and seek support or treatment.

This research is especially timely given the projected demographic shifts in Canada, with an increasing number of immigrant women from South Asian backgrounds (Statistics Canada, 2016). Despite menopause being a universal biological transition, it remains largely overlooked, particularly among immigrant populations, both in research and in healthcare practice. The Menopause Foundation of Canada's landmark report, The Silence and the Stigma: Menopause in Canada (2022),

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[4] Thoughts represent an individual's cognitive, conscious ideas or beliefs. It is what someone thinks about something (Cherry, 2024).

[5] Perceptions represent the way in which an individual interprets or makes sense of an experience – influenced by sensory, emotional, or cultural contexts. It is the way in which something is experienced or felt (Cherry, 2024).

[6] Reproductive health trajectories refer to the continuum of an individual's reproductive and sexual health across their lifespan, encompassing various life stages and the biological, social, and environmental factors that influence these experiences (Mishra et al., 2010).

reveals the steep emotional, social, and health-related toll that stigma and silence take on women across the country (Menopause Foundation of Canada, 2022). Among Canadian women aged 40 to 60 who are going through perimenopause or menopause, more than half (54%) believe the topic is still taboo (Menopause Foundation of Canada, 2022). Nearly one in two (46%) feel unprepared for this stage of life, and four in ten report feeling alone (Menopause Foundation of Canada, 2022). The report poignantly asks: "How can something that happens to more than 50% of the population be such a mystery?" (Menopause Foundation of Canada, 2022).

These findings underscore the urgent need for inclusive, culturally informed research, particularly for communities like immigrant Punjabi women, whose experiences of menopause are often shaped by intersecting factors such as migration, gender norms, and healthcare access (Davis, 2008). Insights from this study not only contribute to the growing body of literature on immigrant health, but also emphasize the importance of cultural humility in healthcare delivery. By foregrounding the lived realities of Punjabi women, this research helps pave the way for more equitable, responsive, and contextually grounded care for all women navigating menopause.

2.3 Research Questions

This research aims to answer the following research questions:

1. What are the beliefs and perceptions of immigrant Punjabi women in the Peel Region regarding menopause, and how do these shape their lived experiences of this transition?
2. How do cultural practices, social norms, and immigration experiences influence the perceptions and management of menopause?
3. What insights from their experiences can inform culturally responsive practices to better address their needs?

Chapter 3
Methods

3.1 Research Design and Approach

To address the research aims, this study employed a qualitative methodological approach, chosen for its strength in uncovering rich, in-depth insights into the meaning ascribed to personal experiences, the motivations behind behaviors, and the ways in which perceptions are shaped (Sutton & Austin, 2015). Qualitative research is particularly valuable for exploring complex, context-dependent social phenomena that answers the 'how' and 'why' questions, making it an appropriate fit for this study (Tenny et al., 2022). Through this methodology, I sought to understand the meaning individuals – in this case, immigrant Punjabi women in the Peel Region – ascribed to their lived experiences while allowing myself as the researcher to interpret this meaning within the context of the research and the research aims (Sutton & Austin, 2015).The approach was designed to explore the cultural and social contexts surrounding menopause among Punjabi women, a group whose experiences have been largely underrepresented in reproductive health research. I aimed to go beyond merely describing participants' statements – striving, instead, to delve deeper into their perspectives and truly understand them (Sutton & Austin, 2015).

3.2 Theoretical Orientation

This study adopted a qualitative research design, specifically using Constructivist Grounded Theory (CGT) as the methodological approach. CGT was well-suited for this research as it allowed for the generation of theories grounded in the data collected from participants' lived experiences (Charmaz, 2006). The goal of this research was to explore the experiences of menopause among immigrant Punjabi women in the Peel Region, focusing on how their cultural, social, and healthcare contexts shaped their understanding of menopause. CGT facilitates an inductive process where themes and patterns emerged organically from participants' narratives, making it particularly effective in capturing the complex and culturally influenced nature of their experiences. This approach is designed to go beyond surface-level descriptions and uncover the underlying social and cultural factors that influenced participants' behaviors and perceptions. By centering the study within the CGT framework, the research was positioned to contribute to both theoretical understandings of menopause in marginalized groups and practical insights into improving healthcare responses.

This research was informed by constructivist theory, which emphasizes that reality is socially constructed through interactions, beliefs, and cultural practices (Berger & Luckmann, 1966). The constructivist orientation aligned with the study's aim to explore how immigrant Punjabi women constructed their understandings of menopause within a specific cultural and social milieu. CGT, as developed by Charmaz (2006), integrates constructivist principles by recognizing that data are co-constructed between the researcher and participants. This theoretical perspective was essential for interpreting the ways in which the participants' cultural background, migration experience, and interactions with the healthcare system shaped their experiences of menopause. Through this lens, the research captured participants' lived experiences, which were then interpreted in relation to broader sociocultural factors shaping those experiences.

3.3 Positionality and Reflexivity Statement

As a researcher with personal and cultural ties to the Punjabi community, my positionality played a significant and multifaceted role in this study. My shared linguistic, cultural, and gendered background with participants enabled a level of familiarity and mutual understanding that facilitated rapport-building and helped create a safe and respectful space for dialogue. Participants often expressed that they felt comfortable speaking openly with someone who could understand cultural references, nuances in language, and the unspoken norms that shaped their personal experiences. This connection, while beneficial in fostering trust, also required ongoing critical self-reflection to ensure that my interpretations did not overshadow or misrepresent participants' intended meanings.

I was acutely aware that my own experiences, beliefs, and assumptions could influence how I engaged with the data. My personal background, being a South Asian woman raised in a diasporic context, and as someone with academic training in public health, meant that I approached this topic with both a personal and professional investment. While this positionality provided depth to my understanding of the socio-cultural environment that participants navigated, it also risked introducing bias or projecting my own interpretations onto their narratives. To address this, I engaged in continuous reflexive practices throughout all stages of the research. Reflexivity was further embedded into the research process through the use of analytic memoing, journaling, and critical dialogue with my supervisor and my peers. These practices allowed me to pause and interrogate how my own positionality might be shaping the questions I asked, the way I interpreted the responses, and the kinds of meanings I uncovered during coding and analysis. I regularly reflected on moments where I

felt aligned with a participant's story, where I saw parallels in their story and in the story and experiences of my mom, as well as instances where the narratives presented by participants challenged my assumptions. These reflections helped me distinguish between participants' experiences and my interpretations, maintaining analytic clarity and integrity.

I remained attentive to power dynamics that are inherent in the researcher-participant relationship. Despite the shared cultural background, my role as a researcher affiliated with an academic institution, and my positionality as someone with greater access to educational and research resources, created a power differential – even when I did not mean to. I attempted to mitigate this through transparent communication, informed consent, and a relational approach to interviewing integrated in humility. My intention was not only to collect data, but also ensure that participants felt seen, heard, and respected. During data analysis, I made a conscious effort to prioritize participants' own words and meanings through in vivo coding and iterative validation of emerging themes. I remained open to complexity, contradiction, and emotion in participant's narratives – making sure that I did not simplify or generalize their experiences of menopause. I acknowledged the limitations of my positionality and welcomed any moments of discomfort or uncertainty as opportunities for deeper learning and critical engagement.

By holding and maintaining space for reflexivity, I aimed to co-construct knowledge that was both contextually grounded and ethically produced, in alignment with the epistemological foundations of Constructivist Grounded Theory. Besides being rooted in theory, I felt that this approach was essential in doing justice to the stories that were shared by the participants. This reflexive strategy strengthened cultural sensitivity, authenticity, and rigor – allowing for insights and findings that are meaningful to theory, but also relevant to the Punjabi, and other marginalized, communities, healthcare, and other community partners.

3.4 Study Site, Population, and Sample

The study was conducted in the Peel Region, Ontario, and focused specifically on immigrant Punjabi women who had lived in Canada for a minimum of five years. The criterion for five years, was selected to capture the experiences of women who had moved beyond the initial newcomer phase and were therefore more likely to have encountered and reflected upon health system navigation, cultural adaptation, and menopausal transition in the Canadian context (Kipp & Busolo, 2025). According to the World Health Organization (WHO), menopause typically occurs between the ages of 45 and 55,

although some individuals may experience premature menopause before the age of 40 (WHO, 2024). As such, I recruited participants aged 35 and above provided a suitable range for exploring diverse menopausal experiences and insights, both anticipatory (for those who have not started menopause yet), and lived (for those who have started menopause). This age group was selected intentionally, as women in this stage of life were likely to have started reflecting on menopause through personal experience or observation (George, 1988). By focusing on immigrant women who have lived in Canada for a minimum of five years, I attempted to ensure that participants have had sufficient time to reflect on their adaptation to a new sociocultural and healthcare environment – ultimately allowing for deeper reflection on how these factors influenced their menopausal experiences.

The focus on the Peel Region was strategic due to its significant and diverse South Asian population, particularly among immigrants who identify as Punjabi. Nearly 60% of Canada's South Asian population resides in Ontario, with over one third living in the Peel Region (Islam et al., 2022). The Peel Region is one of the five major regions that make up the Greater Toronto Area (GTA) and includes the cities of Brampton, Mississauga, and the town of Caledon (Islam et al., 2022). Being home to one of the largest concentrations of South Asians in the Greater Toronto Area, Ontario, and Canada (Islam et al., 2022), focusing on this region provided a rich context for understanding the unique cultural and healthcare experiences of immigrant Punjabi women. The high concentration of the demographic in this area allowed for a more comprehensive exploration of lived experiences, while increasing the likelihood of encountering a wide range of perspectives and challenges specific to the Punjabi community.

As per data presented in the 2019 Comprehensive Health Status Report titled 'The Changing Landscape of Health in Peel', published by the Peel Region, the area encompasses diverse environments, each with unique but overlapping healthcare access challenges, social support structures, and cultural dynamics, highlighting the region's diversity (Peel Region – Public Health, 2019). The choice of this setting is critical as it offers access to a large, diverse group Punjabi of women, many of whom have experienced the challenges of navigating healthcare and cultural adaptation as immigrants. Participants were women who have not experienced menopause, or are currently experiencing menopause, as the research aimed to capture a range of menopause-related experiences from this population. Only first-generation immigrants, those born outside Canada and are now immigrants to Canada (Statistics Canada, 2021), were included, as the focus is on

understanding how cultural and healthcare navigation challenges intersect with their immigration experiences.

Participants were selected using purposive sampling, which is appropriate for qualitative research that seeks to gather rich, detailed data from individuals with specific characteristics related to the research question (Palinkas et al., 2015). In addition, snowball sampling was employed, where initial participants referred others within their social networks who met the inclusion criteria. This method was particularly valuable in community-based research, as it leveraged existing trust and relationships to facilitate recruitment. Consistent with CGT principles, the final sample size remained flexible between 5 to 15 participants. This will be determined by, and rooted in, the concept of 'information power', in replacement of saturation to guide an adequate sample size, as proposed by Malterud and colleagues (2016). 'Information power' suggests that the more relevant information a sample provides for a study, the fewer participants are needed – depending on factors such as the study's aim, specificity, theoretical framework, dialogue quality, and analysis strategy (Malterud et al., 2016). Guided by the themes, depth of insights gathered from participants, and ultimately 'information power', the study aimed to contribute meaningful understanding to the intersection of culture, health, and immigrant experiences, ultimately informing cultural humility in healthcare practices for this population.

3.5 Recruitment Strategy

To ensure the consistent application of the concept of cultural humility, the initial recruitment strategy focused on partnering with community organizations, cultural centers, and religious institutions that serve the South Asian population in the Peel Region. I had intended to leverage my existing relationships with groups such as Laadliyan, Our Kids' Health, Soch Mental Health, Indus Community Services, and Punjabi Community Health Services, as a means of fostering trust and encouraging participation, particularly given the personal and potentially sensitive nature of the study and topic. However, in practice, participants were primarily recruited through a combination of social media outreach on my personal social media profiles, and word-of-mouth dissemination. Word-of-mouth referrals is a method that is highly effective within tight-knit immigrant communities where personal trust is a key factor in engagement (Soare et al., 2021). Laadliyan, one of the community organizations, helped to share the recruitment poster with their community and followers. Broader

outreach and engagement with other community organizations, was deemed unnecessary as there was an almost instantaneous interest in ten individual's wanting to participate.

By creating a culturally respectful recruitment process, the study aimed to reduce barriers to participation and ensure that the women felt supported throughout the process. To ensure that the recruitment strategy does not violate participants' privacy, some key precautions were implemented to make the process respectful of individual preferences and privacy. These precautions included: ensuring voluntary participation, ensuring private and confidential contact methods, anonymity in recruitment materials, and offering discreet avenues to recruitment. It was crucial that all participants, or individuals interested in the study, were made aware that participation is entirely voluntary and that there are no consequences for declining to participate. Participants were made aware that they may withdraw from the study at any point in time where they are no longer interested or no longer feel comfortable in continuing. This reduced any sense of pressure and feelings of obligation. All recruitment materials provided a direct and confidential method for interested participants to express their interest in participating in the study. This was done by having a dedicated email that only the primary investigator will have access to, that participants can access to express interest.

Recruitment materials for the study were carefully designed to ensure participants felt respected and at ease, avoiding any language or details that might make them feel exposed or uncomfortable. The recruitment flyer outlined the purpose of the study, emphasizing the aim to explore the experiences of immigrant Punjabi women regarding menopause and healthcare navigation. It also clearly stated the eligibility criteria, indicating that participants should be women aged 35 and older who have lived in Canada for at least five years (see Appendix A). However, the flyer intentionally avoided detailing any sensitive information related to menopause or the challenges faced by immigrant women, such as cultural stigmas or health-related issues. Instead, it used general language that focused on the broader aspects of the research without explicitly indicating that it involves a potentially stigmatized experience. This approach aimed to create an inviting and non-threatening environment, encouraging participation from those who may otherwise be hesitant to engage. By fostering trust and promoting a sense of safety among potential participants, the recruitment strategy enhanced the study's reach and effectiveness.

3.6 Recruitment Process

3.6.1 Ethical Protocols

This study has been reviewed by and received ethics clearance through a University of Waterloo Research Ethics Board (ORE# 47078).

3.6.2 Outreach and Expression of Interest

Participants were recruited through a combination of social media outreach and community-based engagement strategies. Specifically, the study poster (see Appendix A - D) was shared on my personal and professional Instagram accounts, and my personal LinkedIn account. It was further shared on the Instagram account and monthly newsletter of a community organization with whom I had existing professional relationship, named Laadliyan – a non-profit organization committed to supporting and empowering South Asian women and girls. Recruitment was further aided through ongoing efforts made to increase visibility of the study on a larger scale through presentations made at conferences throughout Canada since April 2024. These conferences included: Advancing Gender Equity in the South Asian Diaspora Conference, Laadliyan (April 2024); Symposium on Aging Research (SoAR) - Network for Aging Research (April 2024); Canadian Association for Health Service and Policy Research (CAHSPR) Conference (May 2024); The Qualitatives: Qualitative Analysis Conference (June 2024); Crossroads Interdisciplinary Health Research Conference, Dalhousie University (March 2025); Research and Practice in Health Sciences Conference, University of Waterloo (April 2025); Canadian Association for Health Service and Policy Research (CAHSPR) Conference (May 2025); and, The Qualitatives: Qualitative Analysis Conference (June 2025). Many individuals who expressed interest in getting involved with this study at early stages re-engaged when recruitment was made live after the study was shared on social media platforms. Leveraging these trusted community connections was instrumental in reaching individuals who might otherwise be hesitant to participate in research related to personal and culturally sensitive topics like menopause.

In addition to formal outreach, word-of-mouth played a central role in the recruitment process. The study poster was organically circulated through informal networks, including family, friends, and community WhatsApp groups. This mode of dissemination helped foster a sense of trust and familiarity with the study, encouraging potential participants to come forward. Many participants

later shared that they had heard about the study through a relative or friend, highlighting the value of interpersonal trust in participant engagement within the Punjabi community.

Recruitment began in February 2025, starting with posts on my personal LinkedIn and Instagram accounts. I chose to begin with these platforms to tap into my professional and social networks, which include community members, healthcare workers, and advocates connected to the study topic. Shortly after my initial outreach, the study poster was shared by a community partner with whom I had an existing professional relationship, Laadliyan, which expanded its reach to individual's within Laadliyan's network. To my surprise, within the first week of recruitment, I had already received interest from ten individuals who met the eligibility criteria and were eager to participate. This immediate and enthusiastic response underscored the importance and relevance of the topic to the community. Following the completion of these initial interviews, I conducted one final round of recruitment to ensure the inclusion of additional voices and a diversity of experiences, with two more individual's expressing interest after hearing about the study through word of mouth, and one more individual reaching out to me after seeing my LinkedIn post.

3.6.3 Information and Consent

When an individual expressed interest in participating, I sent them the Letter of Information (LOI) and consent form electronically. These documents provided comprehensive details about the study, including its purpose, sample interview questions, methods of data collection, measures to ensure confidentiality, data storage protocols, voluntary nature of participation, the right to withdraw at any time, potential benefits and risks of participation, and the ethics clearance information (Refer to Appendix E). This step was essential for ensuring that participants could make an informed decision about their involvement in the research.

After reviewing the LOI and providing consent, participants and I collaborated to schedule an interview at a time and location that was most convenient for them. The majority of interviews (n = 12) were conducted in person at participants' homes. This face-to-face approach allowed for deeper rapport-building and a more comfortable, conversational atmosphere, which is particularly important when discussing personal topics such as reproductive health and aging. Conducting in-person interviews required thoughtful planning to account for travel time, the interview itself, and a respectful wrap-up of the visit, often involving informal conversation and debriefing. One participant (n = 1) opted to complete their interview over the phone. This method was more flexible in terms of

scheduling and still allowed for a meaningful exchange. While the modality was different, care was taken to ensure that the participant felt supported and comfortable throughout the process.

To protect confidentiality, all participant names used in this study are pseudonyms. Participants were invited to choose their own pseudonym as a meaningful and creative way to represent themselves in the research.

Overall, the recruitment process was shaped by a community-centered approach that emphasized accessibility, trust, and cultural sensitivity. My existing relationships within the Punjabi community, both personal and professional, were crucial to fostering participation and shaping an environment in which participants felt safe, heard, and respected.

3.7 Data Collection Strategy

Data was collected through semi-structured interviews, a qualitative method that combines structured and open-ended questioning to explore participants' experiences in depth while allowing new themes to emerge naturally and be probed further by the researcher (Jamshed, 2014). The interviews focused on participants' personal experiences of menopause, their healthcare-seeking behaviors, and the cultural and social factors that influence their understanding of menopause. The flexibility of semi-structured interviews was ideal for capturing the complexity of participants' experiences while ensuring that key research questions were addressed (Ruslin et al., 2022). This approach aligns with the CGT framework, which prioritizes and emphasizes the co-construction of knowledge and meaning between the participant and researcher, allowing for deep engagement with participants' perspectives as new insights emerge, and allowing for the development of theory grounded in the data (Sebeelo, 2022).

Interviews were conducted either in person or virtually, depending on participants' preferences and logistical considerations such as location, availability, and comfort. Each interview lasted approximately 45-60 minutes in length, ensuring enough time to explore key themes comprehensively while remaining flexible for new ideas to emerge during the conversation. A flexible sample size was used to allow for detailed, iterative analysis of the data as themes and patterns developed over time.

3.8 Data Collection and Translation

Participants had the option to conduct the interview in either English or Punjabi, based on their language preference, ensuring that they can articulate their experiences fully and comfortably, and express themselves in their preferred language. It was important for me, as the individual doing the translation, to have a comprehensive understanding of both languages – in this case, English and Punjabi (Yunus et al., 2022). I am a native of Punjab, and grew up speaking, reading and writing in Punjabi. I have formally studied the Punjabi language to further hone my skills and I am currently a trained research coordinator conducting majority of my work in Punjabi. Recognizing the challenges related to translating and interpreting data, and to maintain valid translation and understanding of the original language and conveyed ideas, I aimed to follow a comprehensive guideline for translation (Yunus et al., 2022). Feasible strategies such as consultation and data rechecking to prevent meaning loss and correct meaning assignment, were implemented throughout the study (Yunus et al., 2022).

Moreover, it was also important to keep in mind the differences in translational practices between the representative scheme, where one would translate as literally as possible, versus performative scheme, where one would translate the practical meaning in a conversation, as highlighted by Inhetveen (2012). Keeping in mind the heuristics, linguistics and expressions in conversation, aiming for translation following the performative scheme was helpful in retaining true meaning (Inhetveen, 2012). All interviews were audio-recorded, and those conducted in Punjabi were be translated into English. The translations retained culturally significant terms and references to preserve the richness of the data. This bilingual approach enhanced participant comfort and ensured that culturally specific nuances were captured and reflected in the emerging grounded theory and analysis.

3.9 Participant Profile

A total of 13 participants took part in this study, all of whom identified as immigrant Punjabi women residing in the Peel Region. At the time of the interviews, participants ranged in age from 39 to 58 years, with a mean age of approximately 50. Most participants had immigrated to Canada between the early 1990s and mid-2010s, with the earliest arrival in 1993 and the most recent in 2018. All participants (n = 13) were currently married and living with their husbands. All participants (n = 13) were mothers, with most having two children (n = 11). A few participants (n = 2) had three children,

with one participant (n = 1) having a son as young as six years old, reflecting a wide age range of children across the sample - from teenagers to adult children in their 30s.

Participants also represented a range of educational backgrounds. While some had completed postgraduate education (n = 10), such as Bachelor's (n = 10) or Master's (n = 5) degrees, others reported high school or diploma-level education (n = 3). Specifically, participants held degrees in fields such as arts (n = 6), economics (n = 1), history (n = 1), and computer science (n = 1). A few had completed additional certifications or training in Canada, including diplomas in medical office administration and phlebotomy (n = 1), aesthetics (n = 2), business management (n = 1), and early childhood education (n = 2).

Occupations at the time of interview varied considerably. Some participants were engaged in paid work, including roles in customer service (n = 3), administration (n = 3), social services (n = 2), early childhood assistance (n = 2), real estate (n = 1), and the beauty/cosmetic industry (n = 2). Others identified as self-employed (n = 4), while several described themselves as unemployed, homemakers, or full-time mothers (n = 6). This variety in employment status reflects the diverse lived realities of participants, shaped by migration histories, caregiving responsibilities, and access to opportunities in Canada. A total of twelve (n = 12) participants chose to complete their interview in Punjabi, with one (n = 1) participant choosing to complete their interview in English. The diverse demographic profiles and lived experiences of these participants provided rich and multifaceted insights into how Punjabi immigrant women understand, experience, and navigate menopause within their cultural and social contexts. Participant demographics are presented in Table 1. Participant Demographic Table, below.

Table 1. Participant Demographic Table

Participant Pseudonym	Age	Marital Status	# of Children	Immigration Year	Education Level	Occupation
Ruby	53	Married	2	1993	Bachelor of Arts (BA)	Housewife
Preet	52	Married	2	2004	Bachelor of Arts (BA)	Housewife, Seasonal Warehouse Worker

Rano	41	Married	2	2013	Master of Computer Science, Bachelor of Arts (BA), Early Childhood Education Diploma	Early Childhood Educator
Jass	49	Married	2	2002	Master of Economics, Bachelor of Education (BEd)	Fast Food Worker
Poonam	51	Married	2	1993	Bachelor of Arts (BA), Medical Office Administration, Phlebotomy	Housewife
Aman	47	Married	2	2014	Master of Technology (MTech), Bachelor of Arts (BA)	Amazon Warehouse Worker
Harvey	49	Married	2	1997	Bachelor of Arts (BA), Business Management Diploma, Real Estate	Real Estate Broker
Minnie	54	Married	2	2018	Grade 10	Housewife
Meenu	58	Married	2	2009	High school graduate	Housewife
Nikki	39	Married	2	2004	High school graduate, Aesthetician	Licensed Esthetician

						and Hairdresser
Inder	50	Married	3	2002	Bachelor of Education (BEd)	Housewife
Sheenu	50	Married	3	1999	Master of Arts (MA) in History, Bachelor of Arts (BA) Aesthetician	Licensed Aesthetician and Hairdresser
Neety	52	Married	2	2004	Master of Arts (MA), Bachelor of Education (BEd), Early Childhood Education (ECE) Diploma	Business Owner

3.10 Data Collection Process

Each interview began with a brief introduction in which I shared some personal background, including my role as a graduate student and my own interest in exploring culturally grounded understandings of menopause among Punjabi immigrant women. This reflexive introduction helped establish rapport, reduce hierarchical power imbalances, and encourage a conversational tone (Pessoa et al., 2019). I made it clear that participants were the experts of their own experiences, and my goal was to understand their journeys in their own words (Pessoa et al., 2019). My reflexivity also set the stage that allowed me to engage with the interviewee through elaboration and collective understanding of the contents, answers, and stories shared or expressed by them (Pessoa et al., 2019). Rather than positioning myself as a distant observer, I actively participated in meaning-making alongside participants - listening attentively, paraphrasing for clarity, and inviting elaboration in a way that emphasized mutual understanding. This process aligned with a constructivist grounded theory approach, where data are co-constructed through interaction and interpretation (Charmaz, 2014). It also helped foster a deeper connection that encouraged participants to speak openly, particularly around topics that are often considered private, stigmatized, or culturally sensitive. I framed the interviews as an opportunity for participants to reflect on and narrate their experiences

with menopause, whether they had already entered this stage of life or were anticipating its arrival. I emphasized that they could share as much or as little as they felt comfortable, and that my role was to listen, paraphrase for clarity when necessary, and respectfully probe for further understanding.

At the start of each interview, I asked participants to "tell me a little bit about yourself - your interests, hobbies, and family," which often organically led into discussions about aging, bodily changes, and life transitions. Guided by a semi-structured interview guide (Refer to Appendix H), I allowed participants to speak freely while using open-ended questions and flexible probes to explore areas central to my research aims, such as symptom management strategies, cultural and familial attitudes toward menopause, and experiences with healthcare. My approach was grounded in the principles of Constructivist Grounded Theory, which emphasizes co-construction of meaning and the importance of participant perspectives in shaping the direction of data collection (Charmaz, 2014). While I followed the interview guide to ensure consistency across interviews, I adapted my questions based on participants' responses to allow for depth and nuance. When participants did not bring up certain topics, such as healthcare access, cultural stigma, or support systems, I gently introduced relevant prompts to encourage reflection without disrupting the flow of conversation. These moments provided insight into the barriers and facilitators that shaped their menopausal experiences, particularly in the context of migration and healthcare navigation in Canada. Near the end of each interview, I asked participants to reflect on their journey by offering advice to healthcare professionals working with South Asian or Punjabi women. These reflective questions aligned with community-engaged research values, as they gave participants an opportunity to contribute knowledge that could support culturally sensitive care (Michener et al., 2012).

After the interview, I asked a short series of demographic questions to help contextualize participants' experiences. These included age, year of immigration, educational background, family status, and reproductive history. I made it clear that participants could skip any questions they did not wish to answer. Throughout the interview process, I took field notes and paraphrased participants' responses when needed to confirm my understanding. This practice supported the co-construction of data by allowing participants to clarify or elaborate on their responses (Charmaz, 2014).

While monetary remuneration was not provided, I emphasized the voluntary nature of participation and expressed sincere appreciation for each participant's time and willingness to share their experiences. As a culturally respectful gesture of gratitude, I brought a small bouquet of flowers

to participants whose interviews were conducted in person. This aligned with South Asian cultural etiquette, where arriving empty-handed when visiting someone's home can be viewed as inappropriate or disrespectful. Throughout the research process, I approached each participant's story with confidentiality, care, and deep respect, ensuring that their contributions were treated with the dignity and consideration they deserve. Throughout the interviews, there were occasional moments of silence or awkward pauses, which I interpreted as opportunities to allow participants time for reflection. In these moments, I made intentional efforts to gently reposition the question, offer a follow-up prompt, or engage in casual conversation based on their prior response. My role extended beyond simply gathering data; I aimed to create a space that fostered trust, care, and mutual respect. I approached each conversation with cultural sensitivity and a commitment to listening deeply and without judgment.

Although the LOI stated that there may be no direct personal benefits from participating in the study, many participants expressed, particularly at the end of the interviews, that they found the experience meaningful and personally rewarding. Several participants noted that they had never before discussed menopause so openly and appreciated having a safe, non-judgmental space to share their stories. Many described the conversation as therapeutic - likening it to a session where they could freely "dump" their thoughts and emotions. Participants often commented on how refreshing it was to speak with someone who was genuinely interested in hearing their honest thoughts and lived experiences. They expressed deep appreciation for being listened to without interruption. Interestingly, a common theme that emerged across participants was the suggestion for creating a women's group or "ladies' club" - a dedicated space where conversations about menopause and aging could occur more openly within the community. This feedback not only highlighted a gap in social support but also reinforced the importance of culturally relevant spaces for dialogue and collective healing.

3.11 Data Analysis

The data for this study was analyzed using the Constructivist Grounded Theory (CGT) approach (Charmaz, 2006), which emphasizes theory generation through an iterative process of data collection and analysis. In keeping with CGT's core principles, data collection and initial analysis occurred concurrently for part of the study. CGT provided a flexible, yet rigorous framework for qualitative analysis that emphasized the co-construction of meaning between the researcher and participants

(Charmaz, 2006). It rejected the notion of a singular, objective truth, instead recognizing that knowledge is socially produced and shaped by context, relationships, and positionality (Charmaz, 2006). Given the culturally sensitive and emotionally nuanced nature of the topic of menopause among immigrant Punjabi women, CGT was an ideal methodology to center participants' voices, situate their experiences within broader socio-cultural structures, and remain reflexively attuned to how my own subjectivities, understandings, and internal biases shaped interpretation (Charmaz, 2006).

While the majority of open and focused coding was completed after most interviews had concluded, I began identifying emerging patterns, writing memos, and noting significant codes while still in the process of conducting interviews. This reflexive engagement helped shape follow-up questions, probe emerging ideas, and allowed later interviews to build upon insights from earlier ones. This iterative dynamic between data collection and preliminary analysis ensured that participants' evolving narratives remained central to the construction of meaning throughout the study (Charmaz, 2006).

The analysis proceeded in multiple phases, beginning with open coding, where the researcher identified key phrases, ideas, and concepts from the interviews (Charmaz, 2006). During this phase, data was coded inductively, allowing themes to emerge directly from the participants' narratives without imposing pre-existing categories (Charmaz, 2006). This allowed me to stay open to nuances in participant narratives and aligned with CGT's emphasis on discovering different ways for meaning-making directly from participants (Charmaz, 2006). By prioritizing the perspectives of the Punjabi women, this allowed for a deeper understanding of how they perceive and navigate their menopausal experiences. Following open coding, the study moved into focused coding, where related codes were grouped into broader themes that reflected the major issues and patterns identified in the data (Charmaz, 2006). This ensured that emerging themes could inform ongoing interviews, allowing for adjustments in interview questions, as necessary (Charmaz, 2006). By allowing myself to stay flexible and allowing for emerging themes to guide subsequent questions or interviews, I was able to start synthesizing raw data into coherent categories while also remaining close to participant accounts and narratives (Charmaz, 2006). Finally, axial coding was conducted to explore the relationships between these themes and developed a theoretical framework (Charmaz, 2006) that explains the cultural, social, and healthcare factors that influenced the experiences of menopause among Punjabi women. This helped to uncover the ways in which different aspects of participant accounts and

experiences were interrelated and facilitated the development of a framework that linked themes together to produce one coherent narrative (Charmaz, 2006). Being central to CGT's goal of theory generation, this allowed analysis to move beyond description and allowed for the construction of theoretical understandings that underpinned further research and subsequently helped inform implications in practices (Charmaz, 2006).

The analytic process unfolded in a systematic, iterative, and layered manner, progressing through several key stages: initial/open coding, focused coding, axial coding, and theoretical development. Each phase involved constant comparison across transcripts, codes, and categories, allowing for continual refinement of emerging insights.

3.11.1 Open Coding (Initial Coding)

The first phase of analysis involved a line-by-line examination of the interview transcripts, where I assigned initial codes to meaningful segments of text. This process, also referred to as open or initial coding, was guided by inductive reasoning, which meant that codes emerged directly from the participants' words rather than being imposed from existing frameworks or theoretical assumptions (Charmaz, 2006). I remained close to the data by using in vivo coding where appropriate, drawing directly from the language participants used to describe their experiences. This helped preserve the authenticity and cultural specificity of their narratives. For instance, when a participant referred to menopause as "the fire inside," that phrase became a code capturing both the physical and emotional intensity of her experience. Both the translations and thematic coding were done manually by hand.

This stage was crucial for remaining open to the full range of meanings participants ascribed to their symptoms, social roles, cultural practices, and healthcare encounters. It also helped me avoid prematurely categorizing or simplifying complex experiences. I wrote analytic memos throughout this phase to reflect on my evolving interpretations, pose analytic questions, and document early patterns or tensions in the data.

3.11.2 Focused Coding

Once open coding was complete, I began focused coding by identifying the most significant, frequent, or conceptually rich codes across the dataset. These codes were then used to sort and synthesize larger segments of data. Focused coding allowed for a smooth transition from fragmentation to pattern recognition, which helped to identify emerging categories that reflected the dataset that was collected

– including shared meanings or concerns (Charmaz, 2006). At this stage, I clustered related codes into preliminary categories such as “managing symptoms through tradition,” “secrecy and stigma,” and “feeling dismissed by doctors.” These categories were continuously compared within and across interviews to test their robustness and variation. I revisited earlier transcripts with these categories in mind to ensure consistency and refine boundaries between overlapping themes, ensuring that I moved around subthemes or quotes to themes and categories that best represented them.

This stage remained fluid and iterative. The evolving categories influenced subsequent data collection (i.e., later interviews), allowing for theoretical sampling - a key feature of CGT (Charmaz, 2006). For example, when a category like “gendered expectations in the household” began to surface, I incorporated more specific prompts about gender roles and household labor into later interviews to further elaborate this theme. When these categories emerged, and new data related to these categories became more prominent through interviews, I made it a point to analyze the dataset accordingly to ensure that the conversation was still relevant for the topic of menopause.

3.11.3 Axial Coding

The third phase, axial coding, involved reassembling the data in new ways by identifying relationships between categories and subcategories (Charmaz, 2006). This process went beyond describing what participants said, seeking to understand how different aspects of their experiences intersected and interacted (Charmaz, 2006). I asked questions such as: What conditions gave rise to this experience (i.e. immigration, gendered experience, age)? What were the consequences? What social structures or social determinants of health were at play? How did participants respond or make sense of these realities? What is the underlying mood or context through which the participants are now talking about their experiences (i.e. are they reflecting, are they mad, are they sad)?

This stage helped me map how categories such as “cultural silence,” “community building and support,” and “navigating Canadian healthcare” related to one another and contributed to the broader experience of menopause. These interconnections were visually represented through coding diagrams and memo-writing to assist in building a coherent explanatory framework, as shown in Table 2. Coding Diagram below, also found in Appendix J.

Table 2. Coding Diagram

Experiences, thoughts, perceptions of menopause at the intersect of culture, immigration, and the Canadian Healthcare system	Managing Menopause Through Culture & Familial Practice	• Herbs • Home remedies • Turmeric • Yoga • Squash	• Cultural norms affect health-seeking behaviour and promote secrecy • Gendered roles limit support • Traditional knowledge became a resource and a constraint • Immigration allowed for open conversations • Gaps in generational knowledge about menopause
		• Support • Lack of support • Family Support • Husbands • Children • Elders	
	Cultural Silence and Stigma Surrounding Menopause	• Shame • Embarrassment • Silence • Whispering • Shush, 'shh'	
		• Lack of open dialogue • Lack of conversations • Lack of health literacy	
	Navigating and Accessing the Canadian Healthcare System	• Misdiagnosis • 'In your head' • Dismissal by doctors • Rude behaviour • Low quality of care	

		• Cultural barriers to access • Accessing resources as an immigrant • No agency • Confusion with the healthcare system	

3.11.4 Theoretical Development

The final phase focused on moving from thematic analysis to theoretical abstraction that allowed for the development of analytical categories, serving as the building blocks of the theoretical framework. Grounded in participants' lived experiences, the goal was to construct a theoretical framework that explained how Punjabi immigrant women experienced and navigated menopause within the intersecting contexts of migration, culture, gender norms, and healthcare access. Final themes and subthemes throughout this paper, are also represented in Table 3. Themes and Subthemes Diagram, and found in Appendix K. The resulting theory did not aim for universal generalizability, but rather for contextual depth and conceptual clarity that could inform practical interventions (Charmaz, 2006). In line with CGT's epistemological stance, this theory reflected a co-constructed understanding, shaped both by participant accounts and my interpretive engagement with the data (Charmaz, 2006).

Throughout the analysis, I maintained an ongoing reflexive stance. My positionality as a South Asian woman and public health researcher was critically examined through memoing and field notes, allowing me to interrogate how my own assumptions, cultural familiarity, and emotional responses may have influenced what I noticed, prioritized, or interpreted in the data. This multi-layered analytic process ensured that the richness of participants' voices was preserved, while also producing a theoretically grounded understanding of the social, cultural, and structural forces shaping the menopausal journeys of Punjabi immigrant women in Canada.

While CGT offered a flexible and rigorous approach for theory generation, the reliance on the researcher's interpretive lens presents the possibility to introduce bias or selective attention in the

absence of diverse analytical perspectives (Charmaz, 2006). Additionally, the emphasis on co-construction requires ongoing reflexivity, which can be challenging to sustain consistently across all phases of the research (Charmaz, 2006). Nonetheless, CGT provided a valuable framework to explore the nuanced and contextually grounded understandings of menopause that were often overlooked.

Table 3. Themes and Subthemes Diagram

4.1 Embodiment of Menopause in Everyday Life	4.1.1 Discovery of Symptoms
	4.1.2 Learning on the Go: Lack of Information
	4.1.3 Embodied Stress and Gendered Experience
4.2. Pathways to Seeking Care and Knowledge	4.2.1 Learning About Menopause
	4.2.2 Western Medicine
	4.2.3 Home Remedies and Self-Care
	4.2.4 Building a Community of Care
4.3. Breaking the Silence	4.3.1 Finding a Voice Within: Self-Discovery and Wisdom
	4.3.2 Shifting Cultural Echoes: Immigration as a Key Factor
	4.3.3 Speaking Forward: Breaking Generational Silence and Advice for Providers

Chapter 4
Findings

This section presents the findings from in-depth semi-structured interviews with South Asian Punjabi immigrant women living in the Peel Region. The findings are structured around three overarching themes: Embodiment of Menopause in Everyday Life, Pathways to Seeking Care and Knowledge, and Breaking the Silence to Reclaim Voice and Community. Each theme encapsulates several subthemes that reflect how participants perceived and navigated the menopausal transition in the context of migration, culture, and health systems. These findings aim to offer an in-depth understanding of the sociocultural and emotional landscapes that shaped participants' experiences.

4.1 Embodiment of Menopause in Everyday Life

The theme of embodiment explores how participants initially became aware of menopausal changes and how their bodies acted as sites of meaning-making. Menopause was not just experienced physically but was intimately tied to emotional histories, gendered labour, and unspoken cultural expectations. The physical experiences described by participants were closely intertwined with emotional and psychological responses, suggesting that menopause, for many, was more than a biological event. It represented a broader existential shift, marked by uncertainty, unpreparedness, and evolving bodily awareness.

4.1.1 Discovery of Symptoms

For many participants, menopause began with uncertainty and confusion. They described experiencing unusual symptoms - such as prolonged bleeding, mood swings, and fatigue - without understanding what these changes signified. Lacking anticipatory guidance from family or healthcare providers, they were left to interpret bodily signals on their own. In some cases, women lived with symptoms for months or even years without naming them as part of menopause. This confusion, compounded by limited access to culturally relevant education, reveals how bodily change became a primary source of knowledge.

For example, Ruby, a 54-year-old woman, mother of two, who immigrated to Canada over a decade ago, said she did not know what was happening to her, describing her initial experience in the following way:

"First of all, I have noticed weight gain. Secondly, I noticed changes in my periods. These symptoms, I think, started in 2019. I noticed my period becoming shorter, then they would come less frequently. Now it is completely at a minimum. I didn't know what was happening… I thought something was wrong with me. But no one really talks about these things openly."

For Ruby, as for some other participants, cultural silence, combined with a lack of reproductive health education, created a feeling of being disoriented, emotionally isolated, and unsupported at the onset of menopause. Ruby's narrative highlights the psychological dissonance many women experienced as they tried to make sense of and interpret unfamiliar bodily changes in the absence of culturally or medically informed explanations.

Without knowledge of common symptoms of menopause, some participants began to view their bodies as unpredictable and even frightening. Recalling her experience, Sheenu, a 50-year-old mother of three, noted:

"I had a bleeding problem about 6-7 years ago. This was due to basically a lot of stress. I was bleeding a lot. I went to the doctors for this. They told me that my internal lining was thick. I had to get a surgery for this. After the surgery, they told me that I may or may not have my periods after this. Maybe I would stop them permanently. But my periods were normal after the surgery. After the surgery, my period came about a month later. Then they did not come for 6 months. After 6 months, they happened again for a month. Now, its like they happen but its just spotting."

Her account reflects the bodily unpredictability of menopause and how she navigated it largely through observation and self-monitoring. Like many others, Sheenu used her own experiences as a form of diagnostic knowledge in the absence of formal guidance, relying on experiential knowledge and intuitive interpretation of bodily changes.

4.1.2 Learning on the Go: Lack of Information

The experience of menopause for the Punjabi women in this study was marked by a lack of information and guidance. In the context of their South Asian upbringing, discussing reproductive health, particularly menopause, was often considered taboo or inappropriate. This cultural silence was compounded by migration, which disconnected them from their extended families and traditional

networks of support. Many participants reported that they were unaware of the specific symptoms of menopause or what they should expect as their bodies changed. This lack of knowledge left them feeling unprepared or isolated in their experiences.

Participants repeatedly described having to learn about menopause while going through it. With little to no prior education from family or school, they relied heavily on informal resources. Yet, some also noted that immigration allowed them greater access to public discourse around women's health, revealing a tension between isolation and empowerment. Some women noted that exposure to more open conversations about menopause in Canadian society allowed them to access new information, albeit reactively. For these women, the absence of information meant that they had to navigate the transition to menopause on their own, often relying on trial and error or incomplete knowledge. The cultural expectation of silence around menopause created an environment where these women could not seek advice or share their experiences with others in their communities.

Minnie, a mother of two in her 60s, captured this duality in the following reflection:

> *"I do think that we talk about this very less. But I think that we should talk about this. We should be open about it. In India, people used to talk about it very less. We weren't able to figure out what menopause is, what happens to our body, what we should do to help manage it."*

Minnie's reflection highlights silence within the Punjabi community in India about menopause. There is a deep-seated discomfort that many women feel when discussing menopause, both within their families and cultural community.

Neety, a 52-year-old mother of two, emphasized the generational and cultural gaps in knowledge about menopause:

> *"Culturally there is something in Indian or South Asian culture that no one really shares within the family. The doctors don't tell you anything. Even ladies to ladies, no one tells you anything. So, our grandparents or our grandma never told my mom about it, and my mom never told us about it. Never. No. No one explained it, even women to women, no one explains it to each other. So, in that sense there is a bit of a fear. All the time they felt that if your period started, just 'shush', and go sit inside."*

Echoing other participants, Neety explained that cultural norms in Punjabi communities have historically prevented open discussions about bodily experiences and reproductive health. This silence created a fear of the unknown. She recounted how her family doctor, despite being aware of her symptoms, did not provide her with clear guidance on what menopause was or how to manage it. In her case, the lack of direct communication left her feeling isolated in her journey to understanding menopause:

> *"I was dealing with it by myself. No one knows about it. My husband knew a bit about it. My kids were young at that time. They didn't know that much. So, as a lady you have to deal with it by yourself only. That is when I started to share it with my sisters. They told me a bit about it. Some stuff I asked my family doctor. The family doctor did not specially tell me anything about or for menopause. Like "Yes, you are in menopause. These are the symptoms you may experience". I did ask him about it. He tried to refer me to go on to birth control pills two to three times. The doctor did not tell me anything in straight words. He did tell me that if I want regular periods, then I can start the pills. He did not tell me or outline any of the effects that menopause will have on my health. He did not tell me if I should eat a certain type of food, or take some vitamins. He did not tell me many natural ways to deal with menopause. Like, this is all okay. This is a natural process, let it happen naturally. He did not say that to me. He didn't even tell me that maybe I am starting menopause early. In my mind, it [menopause] should have started from after 47/48, near to 50. In my mind, I felt that it should start later, closer to 50. But I started at 43. He did not tell me about any symptoms of menopause to look out for, for example. And without that information, I did not know anything. I did not know about this. I asked my sister, and she told me a bit about it, and some symptoms."*

This comment contrasts traditional cultural silence with her exposure to more open Canadian discourses around health, highlighting the role of migration in reshaping health knowledge access. Her narrative suggests a shift from isolated coping to curiosity and exploration of resources. It also hints at a shifting generational awareness in diasporic spaces where cultural taboos can be gradually reconfigured. In this way, the learning process itself became an embodied journey - where women's own experiences became tools for understanding, further embedding the theme of embodiment.

4.1.3 Embodied Stress and Gendered Experience

A recurrent theme that emerged from participants' accounts was the connection between their menopausal symptoms and a lifetime of emotional repression, stress, caregiving, and household responsibilities. Many participants linked the onset of menopause to years of bearing the emotional and physical weight of gendered expectations. For these Punjabi women, the experience of menopause was not an isolated event, but the culmination of decades spent fulfilling familial and societal roles that prioritized the needs of others over their own well-being. This expectation of self-sacrifice left little room for personal rest or self-care.

Ruby's reflection on her experience with stress poignantly illustrates how this emotional repression manifested physically, signaling a deep connection between psychological strain and bodily health. Ruby, who had grown up in a family environment where emotional openness was limited, shared this recollection:

> *"I feel more strongly that they [health changes] are more related to stress. Because, if I look at my past, if I consider my life from childhood, my nature is to keep things to myself. Because of this, I would stay just within myself. I wouldn't share much with anyone around me. I used to share very less. All my life I have been internalizing things. My habit of internalizing everything, I feel that is what affected my body. The stiffness, for example, or the unknown pain."*

Ruby's words capture the emotional toll of lifelong self-silencing - a gendered practice common among women in conservative Punjabi families. Her experience suggests that the body became a repository for her unexpressed emotions, with the stiffness and pain she described likely serving as somatic manifestations of years of emotional stress. Ruby's narrative highlights how unprocessed emotional burdens, stemming from both internal family dynamics and societal pressures, became intricately woven into her physical experience of menopause, leading to a long-term psychological strain.

Similarly, Minnie's reflection underscores the gendered nature of caregiving roles that continue to shape women's lives, even in the midst of a physical transition like menopause. In her case, menopause did not provide the space for self-care that might have been expected, as the societal and familial pressures to continue fulfilling household duties remained unchanged:

"Even during menopause, I still had to cook, still had to clean… everything was the same... we do not take care of ourselves properly as much anymore."

Minnie's account reflects the constant nature of domestic responsibilities that many Punjabi women face, even as their bodies undergo significant physical changes. Her words reveal how the expectation to "carry on" regardless of health struggles is deeply ingrained within Punjabi culture, where women are often expected to serve as the emotional backbone of their families. The idea of sacrifice is not just a personal experience, but a cultural expectation, often leading to the neglect of women's health and well-being. In Minnie's case, menopause became another phase of life in which women's needs were subordinated to the ongoing demands of caregiving.

4.2 Pathways to Seeking Care and Knowledge

This theme focuses on the strategies women used to make sense of and manage menopausal symptoms, including their interactions with the formal healthcare system and reliance on informal knowledge and culturally rooted practices. The search for care was often nonlinear and shaped by a balance of trust, familiarity, access, and cultural resonance. These experiences were shaped by differing levels of trust in Western medical systems, generational preferences, and the access to culturally competent providers.

4.2.1 Learning About Menopause

While informal sources, such as family members, especially daughters, friends, and the internet, were often the first source of knowledge about menopause for many participants, there was a growing sense of community-based knowledge sharing. This dynamic showcase how, even in the absence of open discussion about menopause, women leaned on one another for support and education. The informal translation of knowledge from younger family members, like daughters, highlighted a shift in the intergenerational understanding of knowledge. These exchanges also indicated a blend of traditional cultural practices with modern approaches to health, such as how digital platforms and communities empowered women to research, explore and navigate menopause. This came as often beyond what was currently being offered by healthcare providers to these women. There was engagement with family members, friends, and peers to make sense of symptoms and there was an interest in educating themselves. Now, women were no longer navigating menopause in isolation,

within a network of shared experiences. This suggests a shift to a more communal approach to menopause, contrast to the individualistic approach as seen previously.

Sheenu reflected on the role of her daughter in shaping her understanding of menopause:

> *"I see in my family, I know that with my husband, my daughter, my sons, I can talk about this openly. They fully support me. They give me a lot of good suggestions about it as well in terms of what I should do. For example, you hear about menopause, or you search the internet about it. You see that it is all normal. My daughter, for example, tells me all of this. Then after I console myself, I am back to normal and I feel okay. I feel good talking about it with my family. I never felt that I cannot talk about it. We have a very good understanding with one another. We all understand each other very well."*

Sheenu's reflection points to the intergenerational flow of knowledge and how younger family members may serve as conduits for navigating unfamiliar health experiences. This marks a shift from silence to shared understanding within families. It also shows how participants depended on those fluent in both cultural and medical languages to translate their bodily experiences.

Jass, in her late 40s, recalled a conversation with a friend:

> *"Like, last week, I was talking to my friend, and we were just talking about heavy periods and about menopause. I mentioned that I stopped my periods around 10 to 12 years ago and I started menopause. And my friend was very surprised and was wondering how I stopped them. She wanted me to share how I stopped them so that she can stop them herself. I told her that I did not do anything to stop them, my body did them automatically. She was very surprised and concerned. She said "How did you stop them? Tell me too!" in Punjabi.*

Neety reflected on her experience of going through menopause at a time when internet access and online health resources were limited. Looking back, she expressed that the lack of accessible resources during that period made it difficult for her to seek out information or support beyond her immediate circle.

> *"I only talked to my sisters about it basically. Online not so much. It was not that readily available back then I would say. If I had that experience now, then I would say that I would search it up easily online. I could learn more about the symptoms and the ways in which I*

should deal with it. I would now be able to figure out more about it. I could search around now. But I did not have much technology."

Similarly, Harvey, mother of two in her early 50s, mentioned

"Yeah, I did search online. And when talking to friends, some of my friends already have started menopause. Like their periods are finished. So, when I talk to them, they tell me that these are the things they are feeling."

Interestingly, Ruby had a different approach where she felt that avoiding discourse about menopause on the internet was a better way to go about her days:

"Basically, I just talk to my doctor. I also watch some light stuff about it on the internet. I have learnt that if you focus on something too much, for example, if I keep focusing on the negative symptoms about menopause, I believe that it will for sure happen to me. So, I like to mainly think that if something is happening to me, I need to approach it with a positive mindset, and I am always successful with this. If I am sleeping at night and I am down, I wake up in the morning totally refreshed and I finish everything I need to do without thinking about anything else, and the rest of my day goes by smoothly."

This was similar to Inder, a 47-year-old mother of three:

"I tried to read online, but everything is in English or doesn't make sense to me. They don't talk about our Punjabi food, our lifestyle. They don't even know anything about our culture. It's hard to relate because the online stuff is not meant for us."

This interaction reveals how peer conversations served as important learning moments and normalized experiences otherwise left unspoken. It also indicates the informal role of community networks in bridging the knowledge gap. These dialogues also provided comfort and a sense of belonging among women facing similar changes.

4.2.2 Western Medicine

A common theme in this section was participants' frustration with seeking menopause-related care in Western medical systems. Many felt their symptoms were dismissed, minimized, or reduced to prescriptions without proper inquiry or explanation, leading to them feeling like they were not fully being heard or being validated by their healthcare providers. This created a sense of emotional labour

where women were burdened with having to explain and validate their own experiences, only to feel unheard. For these racialized immigrant women, these frustrations were intensified by cultural misunderstandings and racial bias, compounding feelings of invisibility during an already complex life transition. Some participants described positive experiences with physicians who were attentive or culturally aligned. However, others recounted situations where their concerns were ignored or where their menopausal symptoms were not taken seriously. Several women expressed that they expected more support in navigating menopause, but encountered overly simplistic of dismissive responses, instead.

Harvey shared her disappointment with a lack of thorough investigation during a medical visit related to ongoing symptoms:

> *"The issue we faced, we go to the doctor, we explain them this is the issue we are facing. So, what they do is they just tell me, "Okay, you know what? This is nothing. This happens sometimes". I'm not sure why the doctors here are scared of giving you a requisition for a test. I'm not sure. I'm not sure why they're not giving it. So, when a woman finally goes to the doctor, they don't really listen. They just say take this medicine and that's it."*

This sentiment was echoed by Aman, a 48-year-old mother of two, who described the clinical environment as impersonal and rushed, even when she was concerned about potentially serious gynecological issues:

> *"But, now I have a new gynecologist. She isn't really as nice. She has interns working for her. She talks to me less and makes her interns do most of the work for her. I have had this experience twice now. She barely listens to me, even if it is just for a second. But she makes her trainees do more of the work. Like, talking to the doctor versus talking to the trainees is so different. How will the patient be satisfied if the doctor doesn't even talk to the patient?"*

In another instance, Aman described how her doctor's alarming and vague comments left her feeling anxious and unsupported in her menopausal health journey:

> *"My doctor, we went to her for a general check-up 2 months ago, and she basically said "We've given up, there's nothing more that I can do or refer you to". My husband and I were obviously so scared. Like what does that even mean? My husband got so scared hearing this. After doing the biopsy and pap tests, the results were normal, so that helped me feel a bit*

better because at least I know that there isn't something so bad about my health. I even went as far as thinking that maybe I should just get my uterus removed. I know that people get this done in India."

Their experience highlights the emotional labour of seeking care and the frustration of not being fully heard or supported. It signals a perceived disconnect between patient concerns and practitioner responses. These narratives and experiences reflect a desire for more empathetic care, but also a need for information, reassurance, and culturally sensitive communication during menopause.

Other women noted how routine appointments lacked depth when it came to menopause-related discussions. Harvey recalled:

"So, the next visit to my gynecologist, I was expecting to talk to her about my about my cyst, about my results. When I went in, the doctor only did my pap test, no other test, no routine. I think it was just about two minutes, that's it. So I said, "That's it we are doing today?". She said, "Yeah, that's it, we are doing today'.

The brevity in care and the perceived superficiality of clinical encounters, especially during complex life transitions like menopause, made participants feel that their menopause-related concerns were not treated as being significant or deserving of detailed attention. It reveals the participants' desire for meaningful dialogue rather than procedural checklists. Similar experiences point to a broader pattern of biomedical systems prioritizing efficiency over empathetic care.

Sheenu voiced a common concern among participants – the lack of guidance on how to best manage menopausal symptoms beyond medication:

"The problem I have noticed is that doctors don't listen to us very well. Like they should be able to listen to us properly and get to know us better. They should be able to know how we are dealing with these symptoms and stuff. They know that medicines and tablets help with the pain, but what other things can we do or use that are solutions and offer some relief. Or maybe they can send us to a specialist to talk about menopause properly."

In addition, participants' experiences were shaped by broader systems of racial and cultural bias. For racialized immigrant women, the lack of empathy or culturally informed care was not just a shortcoming - it compounded feelings of invisibility. Many viewed these encounters through a lens of

intersectionality, where being a South Asian woman in a Western healthcare setting amplified feelings of marginalization and dismissal.

The lack of culturally responsive care also stood out. Some participants felt that they were not taken seriously because of assumptions about their ethnicity or perceived lack of education. Nikki, a woman in her 30's and a mother of two, for instance, shared:

> *"If I go to a doctor and if he sees that I am a South Asian or Punjabi, they automatically think that I do not know how to speak proper English, or that I do not understand what they are trying to explain to me. They don't think I'm educated."*

Harvey echoed this statement, suggesting that her identity influenced the level of care she received:

> *"The doctors are very dismissive and just ignore you when you talk to them about a problem you have. Maybe if I wasn't a Punjabi woman looking for care, they would maybe take care of me better and listen to me better. But they don't even listen."*

In some cases, participants felt their roles as homemakers were used to diminish their concerns. Neety, seeking help for post-COVID-related symptoms, that may have intersected with menopause, was met with condescending advice:

> *"In 2020, after COVID, maybe because of that vaccine, my immunity was totally damaged. I felt very itchy, my hands and arms were itchy, my full body started getting itchy. I went to my family doctor…he recommended me to go to the specialist dermatologist. So, I went to him too. So, I told him my entire problem, showed him my symptoms, everything. But he just laughed it off. If I said to him "See my hands getting itchy", then all he would say was "Tell your honey to make the dough." He was referring to my husband. "Don't do any housework with your hands". What does that mean? I have many responsibilities inside the house and outside the house. What else am I supposed to do? What else am I supposed to use? No matter what it was, he would just say "Tell your honey to do this chore, that chore". There are thousands of chores, how is my honey supposed to do all the chores? He would never tell me the root cause or cure of anything. Instead, he was telling me how to do my work for me without even listening to me."*

These experiences all illustrate how the intersection of gender, race, and immigration status shaped women's access to compassionate and thorough menopause care. While some women found value in the biomedical approach, many found it to be lacking in its ability to address menopause as a holistic, culturally embedded experience. The perceived gaps in care reflect a broader issue: menopause was often treated as an afterthought in clinical encounters, rather than as a significant transition deserving of time, understanding and tailored support.

4.2.3 Home Remedies and Self Care

Despite the cultural silence around menopause, many participants embraced alternative or traditional self-care methods such as herbal teas, turmeric milk, yoga, and prayer. These practices were perceived as more aligned with their bodies and cultural values than pharmaceuticals. Importantly, home remedies were not solely about physical relief – they functioned as tools of cultural preservation and emotional support. Participants described these methods with a sense of pride, autonomy, and continuity with cultural knowledge. For many, turning to traditional remedies was an act of agency – it became a way to reclaim control over their health in a system that often felt inaccessible or dismissive. However, with menopause being largely unspoken in the community, intergenerational knowledge was still transmitted. The knowledge of these remedies was not framed in the context of menopausal care – but as general women's wisdom, becoming a part of the larger repertoire of home-based, embodied knowledge shared among women. These remedies were not always discussed in direct relation to menopause, but were rather remembered through observation, practice, or nonspecific references to bodily discomfort. Knowledge circulated in indirect, but meaningful ways, was quietly passed down from grandmothers, mothers, or sisters. For example, the act of making turmeric milk or rubbing squash on burning feet wasn't explicitly named as a 'menopausal remedy' – rather the embodied experience allowed participants to recontextualize these practices later on.

Minnie, for instance, reflected on her personal preference for traditional methods:

> *"I started drinking turmeric milk…I felt it helped more than any medicine. I tried all other kinds of things that my doctor recommended, but I always came back to drinking turmeric milk to help me. Growing up, I always saw my mother make turmeric milk to help with all kinds of pain or discomfort. It is all natural, and we always have the ingredients available for us at home."*

This comment reflects a preference for culturally familiar and holistic methods of healing over biomedical prescriptions. Her experience points to the legitimacy and value placed on traditional knowledge systems. For Minnie, home remedies functioned as a culturally resonant form of self-care that offered both physical and emotional support.

Though menopause remained a silenced topic in broader community discourse, knowledge of home remedies was often passed down quietly between women - through mothers, sisters, friends, or elders. These practices existed beneath the surface of everyday life, quietly accessible even when explicit conversations about menopause were rare. The use of these home remedies suggests that knowledge of managing menopause exists within cultural circles – albeit not openly discussed. Women continue to rely on generational knowledge in silence, but still actively seeking care in culturally appropriate ways. These self-care practices, either preventative or curative in nature, can be seen as more than about symptom management – they were used to represent an act of resistance against a healthcare system that may have failed to offer adequate support and may be limited in the mainstream medical discourse. Quiet reliance on cultural remedies showcases health autonomy through intergenerational bonds.

Ruby described a more deliberate and holistic self-care regimen:

> *"And then in 2021, because I always had an interest that I wanted to fix myself using natural remedies, even though my doctors would tell me "wake up in the morning and take a Tylenol to start your day", I said "no". I even tried it for a bit in the starting. But internally, I was not happy with that. Then, I did a lot of praying. And then I found a doctor that I get therapy from – Bowen Therapy. She is natural. She stimulates the muscles by gently touching them. By this, your body's natural system for recovery becomes activated. I started this in 2021, and this really helped me. I can see that monthly, I notice changes in me. I see more confidence. Plus, with some yoga practices, these things have really supported me."*

Ruby's integration of body-based and spiritual therapies illustrates how women actively sought healing practices that aligned with their values and sense of self. Her narrative reinforces the importance of spiritual, emotional, and physical coherence in self-care – going beyond medical advice.

Neety described her frustration with the medical system and how that caused her to turn inward towards traditional practices she knew about:

"I went to this dermatologist so he can help me cure my itchy hands, my itchy body. But I think I knew more than this dermatologist. I knew what to do for my body. I figured it out by myself. Nor did my family doctor tell me anything either. He sent me to the specialist, the specialist said "I don't know, its just eczema". Then I just fixed myself up slowly. I used some herbs, made some oils and creams at home. That's how I cured it. I saw my elders fixing these small issues at home all the time. The medications the dermatologist gave me didn't even help."

Her narrative suggests that watching how watching elders engage in everyday acts of healing provided her with a foundation to draw from when formal care became inadequate – even if the language of menopause was never a large part of those past exchanges.

Others, like Jass, turned to these remedies even when uncertain of their specific purpose:

"Sometimes when nothing else helps, I boil fennel seeds and drink it. My mother used to do this too. I don't know if it really helps. But, it just makes me feel better. It is at least better than taking so many pills for no reason."

This suggests a sense of comfort, rather than a medically targeted intervention – revealing how cultural practices continue to offer emotional grounding.

Sheenu added:

"Like I saw, with my feet feeling like they are on fire, I remember seeing my grandmother rub squash on her feet to help them cool down and feel better. I did this once or twice, and it definitely helped me. I heard this from my grandmother. She used to say that her feet felt like they are on fire, and that she sometimes could not sleep at night. Back then I didn't know anything. But now, I understand it all. Maybe at that time, she was going through menopause and had these symptoms too. Back then they didn't use to take so many medications either. It was all-natural stuff from home. And it always helped them feel better."

Here, Sheenu's retrospective interpretation reframed childhood observations into a newfound understanding of her grandmother's embodied experiences. This demonstrates how embodied practices, passed through generations, offered women tangible ways to care for themselves even in the absence of formal guidance.

These home remedies and self-care methods reveal both a tension and coexistence – while menopause itself was rarely discussed in depth within families and communities, remedies for symptoms that were commonly associated with menopause were still shared or observed. This points to a disconnectedness between the silence around the term 'menopause' and the continued presence of intergenerational health knowledge. In some cases, women may not have initially connected these remedies to menopause until experiencing the symptoms themselves. In others, these practices were generalized approaches to wellness and later, retrospectively, understood as relevant to the menopausal transition. Cultural silence and cultural continuity were not mutually exclusive, rather they coexisted in complex and meaningful ways.

4.2.4 Building a Community of Care

Amid cultural taboos and historical silence surrounding menopause, a quiet but powerful transformation was underway among participants: the emergence of informal, intergenerational, and culturally grounded communities of care. These communities, formed through family conversations, friendships, digital platforms, and shared spiritual practices, served as spaces where women could speak openly, feel emotionally validated, and begin to reframe menopause as a shared, collective experience rather than an isolating one.

For many participants, this shift began within the family, especially through open dialogue with daughters. These conversations not only provided emotional relief but also marked a critical departure from the silence of previous generations. Sheenu reflected on the cultural difference she observed after moving to Canada:

Sheenu reflected on this shift:

> *"In India you cannot talk about it. Even with your parents you cannot talk about it. But here, it is very different. You can talk openly about it with your family and friend circle. Everyone shares their experiences and their solutions with us. I feel that I get good ideas from other people and I learn a lot from them about this too. We can maybe even say our generation is a bit backwards thinking because we grew up with this. But for today's generation it is so important to teach our kids about this type of stuff. Our daughters need the education. Our sons need the education. Women will go through it regardless, so it is important to teach the males."*

Sheenu's reflection illustrates how the act of speaking openly, especially within the household, is a form of community-building and intergenerational empowerment. Her emphasis on involving sons as well as daughters represents a key moment of cultural evolution, where menopause is reframed not just as a women's issue, but as a family experience requiring empathy and shared understanding.

Neety also highlighted how this openness was tied to education and generational progress:

> *"People have changed a lot because of the education system. If the mother is educated, then the mother than teach her daughters, and the daughters can teach their daughters. So, it is generation to generation. At that time, the grandma's would just 'shush' us and tell us to go sit inside, even the mothers. Now, it has changed. I can talk about anything with my daughter. We can share the ideas, we can talk about symptoms, and any change that I feel in my body, I can talk with my daughter. She tells me everything. We talk openly"*

Her words reflect a therapeutic and reciprocal dialogue, where mothers are no longer sole caretakers of knowledge, they are also learners, listeners, and sharers in this new, open landscape. For Neety and others, such conversations were not only informative but healing, allowing women to process their own experiences while equipping their daughters with the language and tools their own mothers never had.

For Meenu, a 59-year-old mother of 2, this dynamic took the form of learning directly from her daughter, now a nurse:

> *"My daughter is now a nurse and she is working in the hospital with older women. She teaches me things now. Like things about hormones and why I feel certain ways or why I get angry or irritated all of the sudden. I feel like I'm learning from her. I am lucky to have help at home."*

This reversal of the traditional parent-child dynamic signals not only a redistribution of knowledge but a transformation in how menopause is navigated - no longer alone, but through trusted support from the next generation.

Ruby added to this shift by noting how her own openness was growing:

"Now, I notice that I am talking a lot more now. My kids notice, my husband notices. My relatives notice too. I can see change in myself now. I am becoming more open. I am able to now see my life in a completely different perspective."

Her evolving perspective was not limited to family interactions. Ruby also engaged in broader informal networks that brought spiritual and scientific knowledge together:

"A few years before, my husbands friends from India called us. I shared my story with them. I felt that they are all very good human beings. I shared with them all of my stress and everything. They suggested that we make a group chat. And now we read books written by the Great Saints. Those books aren't related to religion, but they are a mix of science and spirituality. You can call that spiritual science. And we discussed with them why things like these in women's health happen. And the ways in which we can use yoga to help us. Like in yoga, there is meditation and breathing exercises. So we talked about how when we experience these symptoms, how we can help calm ourselves down and what we should do, and the effects this all has on us. So then we didn't have any difficulty talking about it with each other."

Ruby's account reveals how hybrid forms of knowledge, combining spirituality, science, and embodied experience, were shared communally, offering validation and guidance. These informal support groups reflect the creative ways women are adapting traditional wisdom into their new social realities, building spaces that are culturally resonant yet emotionally contemporary.

Preet, a mother of two in her 50s, shared a positive outlook to having a community to share her experiences with menopause with:

"I feel that okay, this is something that is happening to everyone, and I am not the only one in this world, that everyone has this problem or issue. Ladies have to go through this, and they have to face it happily, and they have to enjoy. I feel that we should enjoy it. We should enjoy every aspect of our life, at every time."

Her words encapsulate a hopeful outlook that menopause, while challenging, can also be approached with acceptance, joy, and collective strength when shared within a supportive community.

Altogether, these narratives point to a transformational shift in how menopause is experienced and understood. Where silence and shame once dominated, women are now cultivating networks of care rooted in trust, openness, and cultural relevance. These communities are not institutional. they are homegrown, relational, and deeply meaningful. They represent a grassroots form of health promotion and emotional well-being, providing models for how diasporic communities can resist isolation through solidarity, dialogue, and shared wisdom.

4.3 Breaking the Silence

While the previous theme focused on intergenerational knowledge-sharing and the evolving role of daughters and younger women in menopausal learning, Breaking the Silence shifts attention to the broader emotional, cultural, and self-reflective processes through which participants are beginning to challenge longstanding taboos. This theme encapsulates a growing desire among participants to speak more openly about menopause and challenge the silences that had defined earlier generations. Through community-building, self-reflection, and advocacy, women began to reframe menopause not as a loss, but as a space for growth and connection. Though cultural taboos were still present, participants expressed a sense of transformation and momentum toward openness.

4.3.1 Finding a Voice Within: Self-Discovery and Wisdom

Several participants described menopause as a period of transformation and inner clarity. Despite the challenges, many found that they developed a deeper understanding of themselves. These narratives illustrate how menopause can also be a gateway to personal empowerment. Some reframed menopausal changes as signs of growth, not decline.

Ruby, for example, spoke to a newfound sense of emotional maturity and self-acceptance that emerged during her menopausal transition:

> *"I don't know if this is related, but I feel that I am more mature now. I have more mature thinking. There is a level of maturity now. But no one really knows that this is due to menopause. But I have noticed some maturity in my own self."*

Her words reveal a subtle but profound shift from confusion and silence to reflection and self-recognition. Although Ruby was unsure whether to link these changes explicitly to menopause, the act of voicing this reflection itself marks a break from internalized silence. By articulating that her thinking has changed, that she feels emotionally more mature, Ruby demonstrates how menopause

prompted a deeper awareness of her inner world. The fact that she connects this maturity to an otherwise stigmatized bodily transition reflects a quiet reclaiming of agency and identity.

Similarly, Neety offered a layered perspective on aging, change, and wisdom:

> *"But, now I can see myself in the mirror I am getting older. So that's a kind of, yeah, sometimes I feel bad about myself and sometimes I feel good too, because we get more mature by the age. But it happens by the age. So many things change in your life and your health. We get more mature by age, but we become wiser too."*

Neety's reflection acknowledges the ambivalence that often accompanies aging - feelings of both sadness and acceptance - but ultimately reclaims the process as one of wisdom and emotional evolution. Her insight into the changes brought by age and menopause speaks to a broader process of self-discovery, in which women begin to see their life transitions not through the lens of loss, but as opportunities for introspection and emotional growth. This duality of mourning youth while embracing wisdom was common in several narratives and reflects the complexity of this life stage.

For many participants, menopause was not just a biological event but a moment of emotional awakening. Women began to reframe emotions like sadness, anger, or fatigue not as signs of weakness, but as valid, human responses to years of labor, caregiving, and emotional repression. Some described how they were no longer willing to suppress their feelings or stay silent about their needs. This emotional un-silencing mirrors the external breaking of cultural silence explored in other parts of this study.

Crucially, this process of self-discovery did not always emerge immediately. For some, it came only after navigating confusion, physical discomfort, and emotional distress. However, what emerged from their reflections was a powerful narrative of resilience and meaning-making. Even in the absence of formal support, participants demonstrated the capacity to reinterpret their experiences through a more empowered lens.

4.3.2 Shifting Cultural Echoes: Immigration as a Key Factor

Migration emerged as both a barrier and as a catalyst for open dialogue about menopause. Immigration functioned as both a disruption and a doorway - disrupting familiar support systems while simultaneously creating new opportunities for reflection, openness, and agency. While it removed traditional support networks, it also offered freedom from cultural taboos and greater

openness to speak about health. Many participants reflected on how immigration offered opportunities to renegotiate previously unspoken experiences and challenge generational silence around menopause. While some missed familial support, others welcomed the opportunity to explore their health outside culturally restrictive norms. In this way, immigration emerged not only as a contextual backdrop but as an active agent in reshaping the menopause experience.

Several participants described how moving to Canada enabled them to break away from the cultural silence they had grown up with in India. For Sheenu, the difference was stark and deeply felt:

> *"In India, people just don't want to learn about this stuff... they'd say "you're crazy" or "your brain doesn't work properly", in Punjabi, if you talk about it."*

Her reflection points to a deeply embedded stigma around reproductive health, where even the mention of menopause could result in social dismissal or ridicule. Within such a context, silence often served as a form of self-protection. Yet, Sheenu's ability to speak openly in Canada, and to name this contrast, signals an important cultural shift catalyzed by migration.

Poonam, a 51-year-old mother of two, echoed this experience, identifying immigration as the turning point in her ability to reflect on and talk about menopause:

> *"In India, for example, ladies just don't even talk about this type of stuff. They hide away from it. I have never heard my parents or my family talk about it. Now that we are in this stage, we talk a bit more about it. But before, there was completely no conversation. Like sometimes I think that we should go to the doctor, and we can if we needed to, if our periods were heavy, for example. But then I think about my parents and my family, and how they didn't even have that opportunity to do that, or even the current ladies living in India don't have that opportunity. We only got this opportunity after coming to Canada"*

Poonam's statement underscores how physical distance from home brought with it emotional distance from cultural taboos, allowing her to reframe menopause as something worth discussing, both privately and publicly. Although she acknowledged the continued presence of stigma in Indian communities, her narrative emphasized the transformative potential of migration in giving women access to dialogue, healthcare, and personal insight that earlier generations were denied.

Harvey's story added further nuance, emphasizing how familial dynamics, household environments, and gender roles continue to shape the extent to which openness is possible, even post-migration:

> *"If I start from back home, when we were kids, even when we grew up, like our parents, our mothers, our aunts, they never brough this up. Maybe they were thinking like this isn't something we want to talk about. Maybe this is something that we want to hide. Like, this is private. Right? So, I would say I never knew it till I came here and till the certain age, like I would say until I was 30/35 I didn't know much about this type of stuff. Like definitely in India and back home, like we never heard about it, not from our - definitely not from our aunties or parents. And also, I think in India, if you're talking about back home, like I would say no one even care like the ladies don't have that help from their husbands or I would say like kids, the older kids. No one's understanding there, like this is, this is what a mother or sister or a wife is going through and we have to be a little patient or show sympathy. And here like when we talk, it's a little bit different here, I would say, but then it depends who you talking to, how's the atmosphere is at your home, how's your partner is, how your kids are? If they're understanding these issues, if they have the knowledge of this, right?"*

Harvey recognized the liberating potential of living in Canada, but also pointed to the unevenness of that freedom, which was still deeply shaped by home dynamics, generational attitudes, and the willingness of men and children to engage with taboo topics. Her reflection highlights that migration alone does not erase silence, but it can create new openings, particularly when paired with education, awareness, and interpersonal support.

For many women in the study, Canada provided a different cultural context, one that made it more acceptable to seek care, ask questions, and voice previously unspoken concerns. The shift from a hierarchical, conformity-driven collectivism to a more emotionally open, community-oriented form of family life allowed women to begin reclaiming aspects of their reproductive health that had long been shrouded in silence. Still, this transition was not uniform. Women navigated it differently depending on their home environments, education levels, partner support, and generational attitudes. Some participants described speaking freely with their daughters and sons, while others still hesitated to bring up the topic within the family. These contrasts reflect the ongoing negotiation between cultural heritage and new social realities that immigrant women must manage.

4.3.3 Speaking Forward: Breaking Generational Silence and Advice for Providers

A significant outcome of this study is the deliberate and hopeful effort participants are making to break the cycle of silence surrounding menopause, not only for themselves but for the next generation. While many women had navigated menopause in confusion, shame, or isolation, they expressed a clear intention to ensure that their daughters, and other younger women, would not have to experience the same. This forward-looking orientation speaks to a broader cultural shift, where personal experiences are being transformed into community insights, advocacy, and generational care.

Neety reflected on her mother's silence and her own conscious decision to do things differently:

> *"From what I remember, when my mother was 45-46 she started her menopause. But she didn't really share anything openly. She didn't talk openly. Even though she was a teacher too. She didn't openly tell us that she is in menopause now, or that she is experiencing symptoms. But, we remember that she felt some changes in her body. She would often go to the doctor to ask some questions. My mother never said a word about it. But I want to be different for my daughter."*

Despite her mother's silence, Neety's choice to speak openly represents a break in the generational pattern. Her words symbolize a commitment to ensuring that silence no longer defines how menopause is experienced. This conscious change represents a turning point: where empowerment is rooted in knowledge-sharing, not just for oneself, but as an act of love, care, and preparation for the next generation.

Participant's stories also underscored how menopause is not just a medical issue, it is deeply relational, impacting family dynamics, communication, and emotional well-being. Harvey highlighted how the failure of healthcare systems to support menopausal women has consequences that extend far beyond the clinic:

> *"Doctors should listen more. This could even save marriages. Just think about that, about their personal life, they might have issues. So just listen to them, what they are saying, help them, because we need help at this stage. Because we can't control these symptoms. We have emotional symptoms, we have family issues. And I think these the doctors, or the physicians*

could save at least these personal issues between the families, between the partners. Emotional issues affect everything at home too."

Her words illustrate how emotional and physical symptoms ripple through households, affecting relationships and stability. The emotional burden of menopause, when left unacknowledged or dismissed, can intensify family tensions. Harvey's insight pushes providers to consider menopause care not just in terms of individual symptom management, but also in terms of its broader emotional and relational impact.

Multiple participants emphasized the inadequacy of care that focused solely on prescribing medication without explanation or emotional support. Sheenu expressed frustration at this biomedical approach:

"They should send us to someone who can talk about menopause properly. Not just give tablets."

Sheenu's comment reflects a broader critique echoed by others in the study: that effective care must go beyond the prescription pad, and instead involve dialogue, empathy, and culturally relevant support. This demand is not for special treatment, but for recognition of the complexity of menopausal experiences, especially among immigrant women whose realities are shaped by cultural norms, gender roles, and migration-related stress.

Rano, a 37-year-old mother of two, advocated for culturally sensitive care:

"[Doctors should] Be a little bit more compassionate and empathetic. Because before any South Asian or Punjabi or other specific culture or demographic woman comes to talk to you, the medical professional, they have enough confliction among, like inside of her already. So, she is already feeling less of. So, she would not want to hear from the medical professional that "It is nothing". So be a little bit more compassionate, be a little bit more empathetic. For her to come and talk to you is already a step ahead for her. It's a difficult step for her to take. So, if she is doing that, just meet her halfway. Or at least let her complete her sentence. Don't put words in her mouth."

Rano articulates the emotional labour involved in even initiating a conversation with a healthcare provider. Her words underscore that for many immigrant women, seeking help is already a major act of vulnerability. What they need in return is not indifference or dismissal, but

compassionate, patient-centred care that listens before prescribing, and validates before diagnosing. Her comment also highlights how cultural humility in healthcare is not a luxury - it is a necessity for building trust and ensuring care that is both equitable and effective.

Minnie, in turn, offered a more hopeful outlook, observing shifts in cultural openness and the growing accessibility of information:

> *"I think that stigma does exist. But I think now it is much less than before. I think that the community is more open to learning about things. There is a lot of information available on the internet. Before, it used to be a very shy conversation to have. I think that everyone shares their experience. Even when I started my periods, I tried talking to my mom about it, and she would whisper and try to explain it to me. She was afraid that others would listen to us talk about this. But now, people are more open about talking about this. It is important that they should talk about it. Before, what it used to be is that kids used to be with us all that time when they were young. But now, some young kids start living out of their homes or go abroad for school or move to a different city. They learn more about this type of stuff. But it is also important to talk about this stuff at home. So that the kids know about these types of topics."*

Minnie's reflection situates menopause within a changing generational and diasporic landscape, where openness is becoming more possible due to migration, education, and digital access. She acknowledges the role of young people living away from home, whether for education or work, in expanding awareness and breaking cultural silences, while also emphasizing the importance of having these conversations within the home to maintain intergenerational connection and care.

Together, these narratives show that immigrant Punjabi women are not only responding to cultural silence, they are actively rewriting the script. Punjabi women are navigating cultural, emotional, and systemic challenges during menopause, but also actively crafting creative, community-rooted, and intergenerational strategies of resilience and care. They are advocating for themselves, for better healthcare, for culturally sensitive communication, and for their daughters. Through candid dialogue, community connection, and self-reflection, they are reshaping how menopause is understood, navigated, and supported within diasporic communities.

Chapter 5
Discussion

This research study explored the beliefs, perceptions, and lived experiences of menopause among immigrant Punjabi women in the Peel Region, guided by a Constructivist Grounded Theory (CGT) approach. Through semi-structured interviews, the study revealed a deeply nuanced, multidimensional understanding of menopause, informed by sociocultural beliefs, migration-related disruptions, gender roles, intergenerational silence, and complex interactions with formal and informal care systems. The findings demonstrate that menopause, far from being a solely biological process, is a culturally, emotionally, and socially embedded transition. This discussion integrates the study's findings with relevant theoretical frameworks, including cultural humility, intersectionality, and feminist health scholarship, to illuminate the complex realities of immigrant Punjabi women navigating menopause in a new cultural landscape.

5.1 Embodied Experience: The Body as a Site of Knowledge, Memory, and Distress

While the previous theme focused on intergenerational knowledge-sharing and the evolving role of daughters and younger women in menopausal learning, Breaking the Silence shifts attention to the broader emotional, cultural, and self-reflective processes through which participants are beginning to challenge longstanding taboos. This theme encapsulates a growing desire among participants to speak more openly about menopause and challenge the silences that had defined earlier generations. Through community-building, self-reflection, and advocacy, women began to reframe menopause not as a loss, but as a space for growth and connection. Though cultural taboos were still present, participants expressed a sense of transformation and momentum toward openness.

Participants first recognized the onset of menopause through their bodies. Symptoms such as prolonged bleeding, fatigue, night sweats, joint pain, and mood changes often signaled a transition that was both physiological and psychosocial. However, for many participants, the absence of anticipatory guidance, from family, community, or healthcare professionals, rendered these bodily changes confusing, distressing, and isolating. Women described their bodies as speaking a language they had never been taught to understand. Without clear language or social scripts to contextualize

their experiences, they struggled to articulate what they were going through, both to themselves and to others.

Women recalled the early phases of menopause as periods of uncertainty and disorientation. The physical symptoms they experienced often did not align with any prior knowledge or expectations. In some cases, participants lacked the words, both linguistically and culturally, to name what was happening to them. Several described experiencing things they had never been taught to expect, such as intense mood swings, anxiety, or prolonged spotting, without knowing these could be linked to menopause. In instances where women did want to speak to someone, they often felt there was no socially or emotionally safe space to do so. This lack of language and vocabulary further contributed to the silence, as women internalized their confusion and distress rather than risk being misunderstood or dismissed. This not only impeded their ability to seek support but also added layers of shame and invisibility to an already difficult transition.

These embodied experiences occurred within the broader context of daily responsibilities and domestic obligations. Many participants emphasized their ongoing roles as caregivers, homemakers, and emotional anchors for their families. The menopausal transition unfolded not in isolation, but amidst the routine labour of cooking, cleaning, child-rearing, and emotional caregiving. The invisibility of their own needs, both physical and emotional, was compounded by cultural expectations to remain strong, composed, and available for others. In effect, these women were expected to perform cultural ideals of womanhood while managing unspoken physiological and emotional upheaval. As such, menopause became an embodied site of accumulated labour, both gendered and emotional, that went unacknowledged by those around them. This aligns with literature that frames the body as a central site of experiential knowledge, particularly for women undergoing health transitions in the absence of cultural discourse (Davey et al., 2021; Martinez et al., 2021). For the women in this study, menopause was not simply just a biological event; it was a deeply lived experience filtered through and shaped by lifetimes of caregiving, emotional suppression, sociocultural expectations, and gendered labor. Women like Ruby, Sheenu and Neety described their symptoms as extensions of unspoken emotional stress, with their bodies becoming both a witness and an archive of distress and endurance. The body, in these narratives, was not just a vessel for hormonal change, it was a witness to cultural silence and pain, and a living record of intergenerational sacrifice.

These findings support an understanding of menopause as a psychosomatic process, where physiological symptoms are inextricably linked to mental, emotional, and cultural histories (Johnson et al., 2024). This is in stark contrast to dominant biomedical models that isolate and medicalize menopause to hormonal change, thus missing the intersectional and embodied realities of immigrant women's health experiences (Felice et al., 2021). Instead, this research highlights the need for menopause to be understood as an outcome of cultural, gendered, and emotional histories, a view supported by feminist and intersectional health literature (Chadda & Deb, 2013; Hamiduzzaman et al., 2021).

The intersection of gender, culture, race, migration, and life course stages must be recognized in both academic literature and clinical care (Tunçer, 2024). Without this, dominant narratives risk marginalizing the complexity of menopause for racialized and immigrant women (Tunçer, 2024). Culture plays a pivotal role in shaping how health is experienced, interpreted, and managed (Griffiths et al., 2022). In the context of menopause, it influences not only symptom perception but also coping strategies, help-seeking behavior, and openness to discussing bodily change (Griffiths et al., 2022). Intersectionality, as both a theoretical framework and a methodological approach, enables a more nuanced analysis of how overlapping identities and systems of power influence women's health (Koehn, 2021). This study contributes to a growing body of health research that calls for the decolonization of healthcare practices and knowledge systems by positioning immigrant Punjabi women as knowledge-holders whose embodied narratives can guide more inclusive, empathetic, and culturally grounded approaches to menopause care (Deol, 2023). Recognizing this complexity is essential, not only for ethical research, but for transforming healthcare systems to truly serve all women with dignity and respect, particularly for women undergoing health transitions in the absence of cultural discourse (Martinez et al., 2021).

5.2 Cultural Silence and Generational Disconnect: A Void of Knowledge

One of the most important findings was the persistent cultural silence surrounding menopause. Many participants described how their mothers and grandmothers never spoke of menopause, menstruation, or aging. The silence was both intergenerational and systemic, reinforced by cultural taboos, gender norms, and the disruptions caused by migration. In traditional Punjabi households, topics related to reproductive health were considered inappropriate for open discussion, particularly between generations, as discussed by Jass, Ruby, Aman, Meenu, and Rano. As a result, the knowledge that

women might have gained through observation or informal conversations was rarely passed down. In the absence of such guidance, women found themselves alone and ill-equipped to navigate the bodily, emotional, and psychological complexities of menopause. However, this silence was not universal. A few participants, particularly those from more urban or educated family backgrounds, such as Neety, Sheenu, and Nikki, recalled limited but meaningful conversations with their mothers or older female relatives. Nikki shared that her mother, for example, had spoken briefly about 'body changes', framing it more as a phase of life rather than a taboo. These moments, though rare, disrupted the dominant pattern of silence and suggested that generational communication around menopause may vary depending on class, location, and education.

Still, for most participants, silence contributed to emotional isolation and heightened the uncertainty surrounding bodily changes. Women often endured symptoms such as erratic periods, hot flashes, and mood swings in silence, unsure if what they were experiencing was normal, abnormal, or even worthy of concern. Without the language or emotional permission to speak about their symptoms, participants internalized their experiences, leading to heightened fear, shame, and confusion. Interestingly, despite this cultural silence, many women still had access to traditional remedies like turmeric milk, boiled fennel seeds, or the use of squash on burning feet, passed down from mothers and grandmothers. However, these remedies were not discussed within the context of menopause. Instead, they were shared as general practices for health and wellness, often without naming the specific transitions they could support.

In this way, home remedies operated as a parallel form of knowledge, silent yet enduring. They became the backbone of self-care for many participants, serving as culturally rooted practices that provided comfort, familiarity, and continuity. Even when women had little understanding of menopause as a life stage, these rituals gave them tools to manage their discomfort and maintain a connection to their cultural heritage. These practices were not just about physical relief; they became forms of self-expression, resilience, and belonging. For immigrant Punjabi women who had left behind their homelands and the communities they once relied on, these embodied traditions offered a powerful sense of identity and rootedness. In a new country, where systems often failed to affirm their needs or perspectives, these remedies anchored them to a culture that still lived through their actions.

Yet, cracks in this long-standing silence were emerging. Participants, like Neety, Sheenu, Harvey, and Ruby, increasingly described engaging in open conversations with their daughters, friends, and even sons, suggesting the beginnings of a slow but meaningful cultural shift. A key catalyst for this shift was increased access to technology and digital platforms. The internet provided women with private, judgement-free spaces to seek information, read others' stories, and validate their own experiences – something that many had lacked during their own menopausal transition (Covolo et al., 2022). As shared by Preet, Jass, Neety and Rano, for women who grew up in environments where reproductive health topics were taboo, the ability to access YouTube, Google, and online blogs or forums would've allowed them to learn anonymously and at their own pace, without the fear of social stigma or shame associated with menopause. Neety, for instance, reflected on how she wished she had access to Google earlier in life. She emphasized that even something as simple as reading another woman's post about hot flashes or mood swings would have made her feel less alone. In this way, digital spaces began to substitute for the intergenerational knowledge that many women lacked. This technological shift is part of a broader transformation in the ways in which menopause is now being understood – as a collective, shareable experience, not as a private burden (Tariq et al., 2023). While previous generations endured menopause in silence, women are increasingly now framing it as a communal journey. Many participants expressed that they now speak to their daughters more openly than their mothers ever did with them. These conversations were not just informative, but became emotional spaces where trust, vulnerability, and mutual care could emerge, disrupting the silence and fostering a sense of connectedness.

Importantly, as the researcher conducting this study, the interviews themselves became sites of intergenerational dialogue. Many participants viewed me not just as a student or academic, but as a daughter-figure. This dynamic shaped how they shared their stories. They spoke with warmth, openness, and a willingness to expose their emotional truths in a way they might not have with a peer or professional. There was space for laughter, tears, memories, and questions, conversations that would likely never have occurred in formal clinical or even familial settings. The research setting became a unique emotional space, one where participants could finally speak the unspeakable and feel heard without judgment.

This intergenerational engagement was profoundly meaningful, not just for the women who were interviewed, but also for the larger cultural narrative around menopause. These exchanges are reshaping the way menopause is understood within immigrant Punjabi communities, breaking

through decades of silence with empathy, courage, and connection. As participants expressed their stories, they also expressed a hope: that by speaking now, they could change the landscape for the next generation, that their daughters, and the daughters of their daughters, would never have to endure menopause in silence. An environment and community where menopause might shift from an isolated experience to a shared, intergenerational journey of empowerment and education.

5.3 The Healthcare Encounter: Marginalization, Distrust, and Cultural Incongruence

Women's experiences with healthcare systems were largely marked by disappointment, frustration, and distrust. Participants described medical visits that were brief, impersonal, and dismissive. Menopausal symptoms were often minimized, misattributed, or reduced to single-dimension problems addressed with quick pharmaceutical solutions such as birth control pills or hormone therapy, without sufficient explanation or discussion of alternatives. Women like Harvey and Aman shared stories of being spoken over, ignored, or condescended to, which not only diminished their trust in the medical system but also reinforced feelings of invisibility and cultural alienation.

These patterns reveal the systemic marginalization of racialized immigrant women within Eurocentric biomedical institutions. The absence of cultural humility, where providers failed to acknowledge a patient's cultural context, communication style, or embodied knowledge, created significant barriers to care. Women such as Nikki and Neety recounted how physicians made assumptions about their education, language proficiency, or ability to understand medical information. Some interpreted these experiences as reflections of deeper biases related to race, gender, and immigrant status. The lack of culturally sensitive engagement not only dismissed their concerns but also invalidated their identities, leaving them to navigate menopause without meaningful clinical support. The concept of cultural humility, which emphasizes continuous self-reflection, openness, and partnership rather than static cultural competence, is especially relevant in addressing these concerns. In a region like Peel, home to one of the largest South Asian populations in Canada, there is an urgent need to integrate culturally humble practices into both clinical encounters and institutional policies. Cultural sensitivity in healthcare is not a supplementary feature, it is essential. For many women in this study, their negative interactions with providers were not isolated incidents but symptomatic of a broader system that was not designed with their realities in mind. Integrating cultural humility would mean recognizing how religion, family roles, intergenerational trauma, and traditional health practices all influence how symptoms are experienced, discussed, and managed.

Despite their frustrations with the medical system, participants did not reject Western medicine outright. Instead, they often used it alongside traditional remedies and practices. Many women recounted turning to advice from their mothers, grandmothers, or women in their community who had lived through menopause. Remedies such as herbal teas, dietary changes, prayer, or yoga were not only accessible and familiar but also grounded in a cultural logic that honored their experiences. These practices, rooted in cultural wisdom, often provided comfort, especially when formal care failed to provide satisfactory support. In these accounts, we see a preference for integrative, person-centered care that respects both biomedical knowledge and traditional ways of knowing. Women sought providers who would listen, explain, and validate their experiences, not simply prescribe and dismiss. This aligns with the "healthy menopause" framework (Jaspers et al., 2015), which advocates for holistic, culturally grounded care that includes psychosocial and emotional support alongside medical intervention. Participants expressed that when they felt truly heard, whether by healthcare professionals, peers, or family, they were better able to manage their symptoms and reclaim agency over their bodies.

The findings from this study therefore reinforce the critical need for medical professionals to undergo training in intersectionality, culturally sensitive communication, and anti-oppressive practices. Such training must go beyond surface-level cultural awareness and engage deeply with the lived experiences of patients. It should be supported by institutional structures that allow for longer appointments, multilingual services, and community engagement. By adopting these practices in the Peel Region, and in other communities with large South Asian or racialized populations, healthcare systems can begin to close the gap between what immigrant women need and what they currently receive. Ultimately, a healthcare system that respects cultural context and lived experience is not only more equitable, but also more effective.

5.4 Self-Care and Cultural Continuity: Reclaiming Agency through Traditional Practices

In response to gaps in the healthcare system, women turned to home remedies and spiritual practices deeply rooted in their cultural traditions. Practices like drinking turmeric milk, performing yoga, engaging in prayer, burning incense, listening to spiritual music, and using herbal teas or spices were common, not only for physical relief but also as methods of emotional grounding, spiritual healing, and cultural coherence. These practices offered a lifeline, a way to feel in control in a context where

formal care often felt inaccessible, invalidating, or dismissive. They created private spaces of reflection, healing, and connection to tradition in the midst of bodily confusion and emotional upheaval. Significantly, these self-care practices were not initially seen as "menopause care." Instead, they were embedded in the rhythms of everyday life and passed down as generalized wisdom for wellbeing. Women inherited them from mothers, aunties, neighbors, or community elders, not through instruction about reproductive aging, but through observation and daily habit. Only retrospectively did participants come to understand how these rituals had been supporting them during their menopausal transitions. This speaks to the quiet circulation of embodied knowledge within Punjabi communities, an inheritance of care that survived despite the absence of language or formal education around menopause.

What emerged from these practices was not just relief from symptoms, but a deep sense of agency, autonomy, and personal alignment. For many women in this study, who had uprooted their lives from India and migrated to Canada, leaving behind their families, communities, and the social scripts that had shaped their identities, self-care became a critical act of grounding. In a new country where they often felt culturally invisible and institutionally marginalized, these practices gave them something familiar, something they could control, and something that reaffirmed their sense of self. Through the preparation of a specific tea, the repetition of a prayer, or the ritual of massaging oil into the scalp, women re-established a relationship with their bodies and with a culture that had otherwise been silenced in public domains. In this context, self-care becomes an act of resistance. Resistance not in an overt political sense, but as a quiet reclaiming of space, identity, and dignity in a world that had largely failed to see or support them. In the face of a healthcare system that often treated them as one-dimensional patients, or worse, failed to see them at all, these women turned inward and toward one another. They built informal networks of care, shared tips and remedies through conversation or WhatsApp groups, and reminded themselves that they had tools worth trusting. These practices challenged the dominance of biomedical narratives that rendered cultural knowledge obsolete, instead asserting that traditional practices are valid, effective, and worthy of respect.

For Punjabi immigrant women, who are often navigating layers of loss, of language, social status, kinship, and familiarity, these practices serve as forms of resilience. They restore a sense of belonging by reactivating cultural memory and familial ties, even across oceans. The preservation and adaptation of these practices in a Canadian context reveal the dynamic nature of cultural continuity: it is not static but constantly negotiated in response to one’s environment. Yet it is precisely this

continuity that allows women to feel rooted, whole, and capable amidst personal and systemic transitions.

To truly support the wellbeing of these women, our communities and healthcare systems must recognize and affirm the value of traditional self-care practices. This means creating spaces, both formal and informal, where such practices are not merely tolerated, but celebrated. Community programs, health clinics, and wellness initiatives should actively include and validate cultural practices as integral to health promotion. When women are respected for their choices, affirmed in their cultural identity, and provided space to engage in care that feels authentic, they are more likely to thrive. Practicing self-care in culturally resonant ways should not be a solitary struggle, it should be a supported, shared, and dignified part of community life.

5.5 Building Communities of Care: Toward Collective Empowerment

Perhaps the most hopeful outcome of this study is the growing emergence of intergenerational dialogue and community-based support structures that are helping to reshape how menopause is understood and experienced. Participants described open conversations with their children, particularly daughters, and the formation of informal peer networks where they could share stories, seek advice, and feel emotionally validated. These interactions marked a powerful departure from the silence and isolation that characterized the menopausal experiences of previous generations. Rather than experiencing menopause as a private, stigmatized event, many women in this study were engaging in collective conversations that fostered a sense of solidarity, understanding, and healing.

Immigration itself played a catalytic role in fostering this transformation. While migration often entails loss, of social networks, cultural familiarity, and extended family structures, it also opened the door for value shifts and new ways of thinking. Many participants noted that living in Canada allowed for a greater degree of openness in their families. As Sheenu reflected, "Back home, we didn’t talk about these things. Here, I feel like I can tell my daughter or even my son. We are more free in our thinking now." This change is particularly meaningful when viewed through the lens of collectivist traditions in Punjabi culture. Traditionally, Punjabi families are interdependent, multigenerational, and guided by values of respect for elders, modesty, and social conformity, qualities that often inhibit open discussions about reproductive health. However, what emerged in this study is a shift from a closed, hierarchical model of collectivism to a more community-based, emotionally open version. Rather than upholding silence in the name of family honor, women are

now leveraging their collectivist values to build community support systems and intergenerational bridges. This shift has transformative implications for future generations. As the “hush culture” begins to erode, younger women are being raised in environments where menopause is no longer taboo but a natural, shared, and manageable life stage. Several participants described how their daughters were already more informed and comfortable discussing reproductive health than they had ever been. Neety noted, "My daughter knows more than I did at her age. She Googles everything and then comes and tells me." This knowledge-sharing not only empowers younger women but also offers healing and validation to older generations who are finally able to speak their truths.

Crucially, many participants also emphasized the importance of involving men, fathers, husbands, sons, in these conversations. Menopause does not occur in a vacuum. It affects relationships, household dynamics, and emotional wellbeing within the family unit. Several women voiced a desire for men to be better educated so they could offer support rather than confusion or withdrawal. As Preet stated, "If my husband knew what I was going through, he wouldn’t have just said ‘go lie down.’ He would have understood that it wasn’t just me being emotional - it was my body changing." Including men in educational initiatives and community discussions around menopause can play a vital role in dismantling stigma and fostering a culture of empathy. It also repositions menopause from being a "women’s issue" to a shared family experience, one where emotional labor, caregiving, and understanding are more equitably distributed. When men are informed, they are more likely to validate their partners’ experiences, contribute to emotional support, and reduce the pressures women feel to remain stoic or silent.

In many ways, the interviews themselves became a living example of this evolving community of care. Participants often reflected that speaking to the researcher, whom they saw as a younger, trusted member of their community, gave them the freedom to express emotions and experiences they had never shared before. There was a sense of relief, empowerment, and connection that permeated these exchanges. These moments of mutual trust and shared identity highlight the potential of intergenerational dialogue not just as a method of knowledge transfer, but as a deeply human practice of care.

Altogether, this evolution in care, toward open dialogue, collective understanding, and inclusive support, signals the potential for long-term cultural change. It points to a future where Punjabi women, and other immigrant women like them, can experience menopause not as a silent

burden, but as a supported, visible, and validated chapter of life. When communities come together to affirm these experiences, we move closer to building a society where all women feel seen, heard, and cared for (Tariq et al., 2023).

Chapter 6
Contributions, Implications, and Significance of the Research

6.1 Addressing a Critical Gap in Menopause Research

This study makes a timely and important contribution by centering the menopause experiences of immigrant Punjabi women, a group largely overlooked in mainstream reproductive health literature and healthcare practice. Existing research often reflects Western, biomedical perspectives, failing to account for how migration, cultural norms, gender roles, and healthcare access uniquely shape menopause for racialized immigrant women. By using CGT, this research generates a nuanced, culturally grounded framework that highlights how social context, lived experience, and cultural meaning-making intersect to shape health narratives.

The study fills a significant gap in the reproductive health literature by offering an intersectional lens on menopause, one that recognizes the layered impact of immigration, sociocultural norms, and intergenerational silence on how Punjabi women interpret, experience, and manage menopause. Rather than approaching menopause solely as a biological event, this research reframes it as a deeply social and cultural experience. It contributes new conceptual understandings of how silence, shame, resilience, and community support manifest in menopause journeys within immigrant communities.

6.2 Practical Contributions to Healthcare and Policy

The findings have meaningful implications for clinical care and public health policy. Engaging with healthcare providers, policymakers, and community organizations will help guide the creation of targeted healthcare interventions that address the specific barriers these women face in accessing care. This can lead to better management of menopausal symptoms, increased utilization of healthcare resources, and an overall improvement in the quality of life for this population. Healthcare providers must move beyond one-size-fits-all models and instead adopt care strategies grounded in cultural humility and linguistic accessibility. For example, several women in the study described being dismissed or misunderstood by their physicians, which led them to rely on traditional home remedies or spiritual practices. Culturally humble care in this context means more than translation. It requires a genuine recognition of women's lived realities, emotional needs, and embodied cultural knowledge.

Healthcare systems should incorporate longer, culturally sensitive consultations, fund interpreter and cultural liaison roles, and create space for holistic wellness practices, whether that includes learning more about traditional remedies such as turmeric milk or squash, or prayer, meditation and yoga. Concrete changes could also involve designing menopause education materials in Punjabi, delivered through trusted channels like Gurdwara's, WhatsApp groups, or community women's circles and organizations dedicated to educating and empowering South Asian women – such as Laadliyan. These findings provide actionable insights for improving care for immigrant women and reducing the social isolation, confusion, and stigma associated with menopause.

6.3 Community and Public Health Impact

This research offers direction for community health programming and health education. It highlights the power of informal care networks, such as mother-daughter conversations, intergenerational storytelling, and peer-led support groups, which women already rely on to make sense of menopause. Public health initiatives could legitimize and incorporate these culturally embedded support systems into formal outreach strategies. For example, community-based workshops, peer-led menopause education circles in Punjabi, and health campaigns through local South Asian radio or social media platforms could help normalize menopause-related conversations and reduce intergenerational silence.

The study also speaks to the need for medical education reform and institutional accountability. Institutions must embed training in intersectionality, cultural humility, and anti-racism, into the core curriculum so that future healthcare professionals are better equipped to support diverse populations. As highlighted by the Menopause Foundation of Canada, this can mitigate the systemic biases that alienate racialized immigrant women (Menopause Foundation of Canada, 2022). This includes recognizing how gender, immigration status, language, and life course events shape each woman's encounter with menopause. By incorporating these principles into clinical training and daily practice, healthcare providers can build trust, deliver more relevant care, and contribute to dismantling structural barriers that perpetuate marginalization. Simultaneously, community-based organizations should be funded and empowered to co-create wellness programs that incorporate traditional self-care practices, intergenerational mentorship, and spiritual wellbeing as being valid and central to health.

This study can play a pivotal role in reducing stigma around menopause, encouraging open dialogue, and promoting awareness of women's health issues in communities where these topics are often considered taboo. By fostering an environment that empowers women to seek support and advocate for their health, the study contributes to a culture of proactive reproductive well-being.

6.4 Reflecting on Scope and Limitations

While the findings of this study are not statistically generalizable due to the small, qualitative sample size, they offer deep, contextual insights that can inform both practice and further research. Rather than aiming for universal conclusions, the study embraces transferability, the ability of others to draw meaning and relevance from the findings in similar contexts. The strength of the study lies in its ability to amplify the voices of Punjabi women, illuminate underexplored cultural narratives, and offer concrete directions for more inclusive healthcare.

As a qualitative study grounded in lived experience, it seeks to inspire further research, challenge dominant assumptions, and enrich our collective understanding of immigrant women's health.

Chapter 7

Study Limitations, Mitigation Strategies, and Future Directions

7.1 Methodological and Sample Limitations

This study offered meaningful insight into the experiences of menopause among immigrant Punjabi women in Canada, yet several limitations should be acknowledged. First, the sample size was relatively small and non-random, consisting of women who were willing and able to participate in semi-structured interviews. This self-selection may have resulted in overrepresentation of individuals who were more reflective, articulate, or comfortable speaking about menopause – which is a topic often considered sensitive or taboo within the Punjabi community. As such, the perspectives of women who are more socially isolated, less acculturated, or reluctant to speak openly may not have been fully captured.

To mitigate this, I employed maximum variation sampling to recruit participants from a range of socio-economic backgrounds, education levels, immigration timelines, and comfort levels with English and Punjabi. This strategy helped ensure that the study captured diverse lived experiences and did not solely reflect the voices of more assimilated or outspoken individuals. In practice, the recruitment process benefited from being shared across multiple platforms such as academic conferences, my personal Instagram and LinkedIn, as well as Laadliyan's social media channels, which allowed the call for participants to reach a wide audience. As a result, interest came from individuals across different walks of life, including those whose mothers had little formal education to those who themselves held university or master's degrees. The variation in participants emerged somewhat organically due to the diverse networks that engaged with the recruitment poster. Additionally, I monitored emerging themes during data collection and sought to include underrepresented perspectives as interviews progressed, in alignment with Constructivist Grounded Theory principles.

7.2 Geographic and Contextual Constraints

All participants resided in the Peel Region, a multicultural area with a significant Punjabi population and established immigrant support networks. While this enriched the study's cultural relevance, it also limited transferability to Punjabi women in other contexts, such as other cities in Ontario and beyond, where access to community networks, healthcare, and social support may differ. Although

the findings offer valuable depth, they may not fully reflect the experiences of Punjabi women living in geographically or culturally dissimilar environments.

7.3 Language and Translation Challenges

Interviews were conducted in either English or Punjabi, depending on participants' preference. While this bilingual approach enhanced accessibility and inclusivity, it introduced the possibility that certain linguistic nuances, idiomatic expressions, or cultural meanings were lost during translation. To address this, I worked closely with participants to clarify meaning where needed and to preserve culturally specific expressions. Reflexivity was a key component throughout this process. I continuously reflected on how my positionality and language skills influenced the interpretation and representation of participants' narratives.

Translation into English was conducted for all quotes included in the final thesis, regardless of the language in which the interview was conducted. One interview was conducted entirely in English did not require translation, whereas all the other interviews conducted in Punjabi were selectively translated based on relevance and quotation use. This decision was based on analytical needs and participant consent. Every effort was made to ensure that translated segments retained the integrity of participants' original meaning and voice.

7.4 Cultural Humility and Participant Comfort

Given the taboo nature of reproductive health within many Punjabi households, participants may have hesitated to share deeply personal information, particularly regarding topics such as emotional well-being, sexuality, or conflict within family systems. Despite efforts to foster trust, there remains the possibility that some narratives were withheld or softened due to cultural norms surrounding modesty and privacy. To mitigate this, I conducted interviews in the participants' homes which was a familiar, culturally safe setting for the participants. I also emphasized confidentiality and the voluntary nature of participation throughout the process. The interviews were conducted in a respectful, non-judgmental tone, with rapport-building as a core component of each interaction. Additionally, using reflexivity as a guiding principle, I explicitly avoided a deficit-based approach[7] throughout the

[7] A deficit-based approach refers to a way of thinking that views marginalized communities primarily through what they are perceived to be missing, such as education, access to resources, or willingness to comply with dominant systems (Davis & Museus, 2019). Rooted in colonial and Eurocentric assumptions, this perspective positions Western norms as the standard and often places blame on the communities for not complying (Davis

process. Instead, I approached participants as experts of their own lived experiences, centering their resilience, insight, and cultural wisdom. This framing helped reduce shame and encouraged open, affirming dialogue. This strategy was not about omitting difficult topics, but rather about avoiding narratives that unintentionally portray women or communities as deficient or backward.

7.5 Time and Resource Constraints

The process of conducting, transcribing, and translating interviews, particularly in two languages, was time-intensive. Not all interviews required full translation, depending on the language used and the extent to which excerpts were included in the final analysis. However, prioritizing quote translation and accurate representation in English did add to the resource demands of the study. To manage this, I developed a clear timeline and worked closely with my committee and community members to streamline recruitment and interview logistics. Tasks were scheduled strategically to avoid bottlenecks and ensure thorough, reflective analysis. Despite these constraints, the quality and depth of the data were not compromised.

7.6 Future Research Directions

This study opens several promising avenues for future research. To build on the insights generated here, larger and more geographically diverse samples are needed to better capture the breadth of menopausal experiences across South Asian immigrant communities in Canada. Including participants from other areas in Ontario, or provinces beyond Ontario that welcome large groups of South Asian immigrants, could help uncover regional variations and highlight context-specific barriers or supports. Future studies could adopt longitudinal designs to explore how women's experiences evolve over time, from perimenopause through menopause. This would provide a deeper understanding of how symptoms, coping strategies, and healthcare needs shift across different stages of reproductive aging. Comparative studies across South Asian cultural, linguistic, or religious groups (e.g., Sikh, Muslim, Hindu communities) could also illuminate important distinctions in how menopause is understood and experienced.

& Museus, 2019). Throughout the 20th century, this approach shaped research and policy by focusing on communities' shortcomings, risks, and vulnerabilities, rather than recognizing their strengths, resilience, or lived realities (Davis & Museus, 2019).

There is also significant value in exploring the experiences of second-generation South Asian women, who may negotiate cultural norms differently than their mothers. Investigating how acculturation, intergenerational dialogue, and shifting gender roles influence menopause perceptions can reveal how cultural narratives evolve across generations. Broadening the scope of analysis to include men, extended family members, and healthcare providers would also offer a more holistic view of the social and institutional dynamics that shape women's health decisions, stigma, and support systems. Understanding how menopause is discussed, supported, or silenced, within families and clinical spaces can deepen our understanding of the broader reproductive health ecosystem.

Finally, future research should examine the growing influence of digital platforms, including WhatsApp, online forums, YouTube, and TikTok, as spaces where menopause knowledge is shared and reinterpreted. These platforms may serve as critical tools for health literacy, storytelling, and peer support, particularly for those who may not have access to formal healthcare or culturally relevant education. As digital spaces increasingly shape how diasporic communities engage with health information, they warrant serious attention in research and policy design. Together, these future directions will help expand and refine the culturally responsive care models needed to support immigrant women navigating menopause in Canada and beyond.

Chapter 8
Conclusions

This study offers a critical and in-depth examination of the beliefs, perceptions, and lived experiences of menopause among immigrant Punjabi women in the Peel Region. Using a Constructivist Grounded Theory approach, it revealed that menopause is far more than a biological event - it is a profoundly cultural, emotional, and relational journey, influenced by gendered expectations, generational silences, migration experiences, and structural barriers within healthcare. By bringing forward the voices of women who are often marginalized in dominant health discourses, this research addresses a significant gap in the literature and offers valuable insights into how immigrant women navigate menopause in culturally specific ways.

At the heart of the findings is a powerful narrative of silence and resilience. The intergenerational silence surrounding reproductive health created confusion, fear, and emotional isolation for many participants. Yet, these same women demonstrated remarkable agency by engaging in self-education, sharing knowledge with their daughters, and reclaiming cultural practices as forms of healing and empowerment. Their experiences reveal a complex interplay between tradition and transformation, where home remedies, spiritual practices, and embodied knowledge persist alongside emerging conversations facilitated by younger generations and digital communities. Importantly, the findings expose systemic shortcomings in the Canadian healthcare system, particularly in the areas of communication, cultural competence, and responsiveness. Many participants felt dismissed, misunderstood, or reduced to their symptoms, highlighting the need for a healthcare paradigm that values lived experience and cultural specificity. The call for culturally humble, person-centered care resonates throughout the narratives, emphasizing that meaningful healthcare must not only address physical symptoms but also validate cultural identity, emotional needs, and the cumulative impact of gendered labor and migration-related stress.

This study also challenges the positioning of Western biomedical approaches as the default or superior framework for understanding and treating menopause. Instead, it advocates for integrative care models that incorporate traditional knowledge, community-based resources, and intergenerational dialogue. By highlighting the value of informal support systems - such as WhatsApp groups and mother-daughter conversations - the research underscores the importance of expanding our definitions of health infrastructure to include culturally grounded, peer-based networks. The

implications of this study extend beyond the Punjabi community, offering a model for how culturally attuned research can inform inclusive health policy and practice. It calls on healthcare providers, educators, and policymakers to reimagine menopause care in ways that are linguistically accessible, culturally affirming, and structurally just. Equally, it invites scholars to continue investigating how intersecting forces - such as race, gender, class, and migration - shape reproductive health experiences across diverse populations.

In conclusion, this research positions immigrant Punjabi women not as passive recipients of care but as active agents of knowledge, adaptation, and change. Their stories illuminate the limitations of current healthcare systems while simultaneously offering a blueprint for more inclusive, empathetic, and culturally grounded approaches to menopause. When these women are seen, heard, and supported within their cultural contexts, menopause becomes not a moment of silence and suffering, but a powerful rite of passage - a transformative chapter marked by wisdom, resilience, and renewed connection to self and community.

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Appendix A

Recruitment Poster - English



Appendix B

Recruitment Poster - Punjabi



Appendix C

Recruitment Posts – English





Appendix D

Recruitment Posts – Punjabi





Appendix E
Letter of Information (LOI)

Project Title: Exploring Menopause Through a Cultural Lens: Beliefs, Perceptions, and Experiences of Immigrant Punjabi Women in the Peel Region

You are invited to participate in a study designed to deepen the understanding of the unique experiences of South Asian Punjabi immigrant women navigating menopause. This research aims to explore how cultural beliefs, social norms, and migration challenges shape their perceptions and management of menopause, with the goal of informing culturally responsive and equitable healthcare practices.

This study will be undertaken by Tanveer Randhawa, a graduate student of the School of Public Health Sciences at the University of Waterloo, under the supervision of Dr. Elena Neiterman.

What You Will Be Asked to Do:

Participation in this study is voluntary. It will involve taking part in an open-ended interview, either in English or Punjabi, that will require approximately 45-60 minutes to complete. The interview will take place either over the phone, in-person or on Zoom/Microsoft Teams at a mutually agreed upon time. You may choose to have your video off for the duration of the interview, if the interview is taking place via Zoom or Microsoft Teams. The interview will be conducted over an online platform, Zoom or Microsoft Teams. Zoom and Microsoft Teams have implemented technical, administrative, and physical safeguards to protect the information provided via the Services from loss, misuse, and unauthorized access, disclosure, alteration, or destruction. However, no Internet transmission is ever fully secure or error free. University of Waterloo researchers will not collect internet protocol (IP) addresses, or other information which could link your participation to your computer, or electronic device without first informing you.

With your permission, the interview will be audio-recorded and video-recorded to facilitate the collection of information, and later transcribed for analysis. During the interview, you may decline to answer any of the interview questions and/or share your personal information with the researchers. Furthermore, you may withdraw from this study at any time by advising the researcher without any negative consequences. If you decide to withdraw, we will erase the interview transcript and all the research notes that were taken during the interview process.

At the end of the interview, you will be asked some demographic questions. These questions are included to provide important context for analyzing the collected data. Understanding participant's backgrounds, such as age and education, helps ensure that the findings accurately reflect diverse perspectives. Your responses will remain anonymous, and will only be used for research purposes.

Confidentiality:

Your identity will remain confidential. To protect your confidentiality, any personal identifying information will be removed after the transcription of the interview. Your name, or any other personal identifying information will not appear in any research papers or publications resulting from this study. To protect your confidentiality, we will erase the audio recording and video recording of the interview right after we transcribe it, and only the transcription with an assigned code will remain. Your signed consent form and anonymized interview transcript will be stored as separate encrypted files on a password-protected computers of the researchers and will be only accessed by the research team. All records are destroyed according to University of Waterloo policy.

You can withdraw your consent to participate and, if you wish to do so, have your data destroyed at any time during data collection and analysis. You will not be able to withdraw consent once the final thesis has been submitted, approximately in June 2025, or findings are shared with the public. Any quotations from transcripts used in papers, reports, publications, or presentations from this research will remain anonymous and may be presented with only the information of the participant that is important to the topic being discussed (e.g., ethnicity or gender).

Audio recordings and video recordings of the interview will be deleted securely from all storage devices, after transcription. Data will be kept for a minimum of 7 years after the thesis defense on a password protected personal computer, backed up on a secure cloud storage device with end-to-end encryption.

Benefits and Risks of Participating in the Study:

Participation in this study may not provide any personal benefit to you. We hope the data collected will advance our understanding of the experiences of menopause in immigrant Punjabi women. Risks of participating in the study are minimal as participants may experience embarrassment, worry, and regret over the revelation of personal information. This will be mitigated through voluntary and

informed participation, skipping questions, breaks, withdrawing, etc. In addition, participants will be provided with support resources at the end of the study (or as needed).

Research Ethics Clearance and Further Questions:

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (REB 47078). If you have questions for the Board, contact the Office of Research Ethics, toll-free at 1-833-643-2379 (Canada and USA), 1-519-888-4440, or reb@uwaterloo.ca.

For all other questions regarding this study, or if you would like additional information to assist you in reaching a decision about participation, please contact Tanveer Randhawa at tkrandha@uwaterloo.ca, or the study supervisor, Dr. Elena Neiterman at eneiterman@uwaterloo.ca.

I look forward to speaking with you and thank you in advance for your assistance in this project.

Sincerely,

Tanveer Randhawa

Student Researcher

Appendix F

Consent Form

By signing this consent form, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

I have read the information presented in the information letter about the study being conducted by Tanveer Randhawa and Dr. Elena Neiterman, with the School of Public Health Sciences, University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that I have the option of allowing my interview to be audio recorded and video recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in the project paper and/or publications to come from this research, with the understanding that the quotations will be anonymous. Participant's will be able to select a pseudonym, or a false name, for themselves.

I was informed that I may withdraw my consent at any time by advising the student researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (REB 47078). If you have questions for the Board, contact the Office of Research Ethics, toll-free at 1-833-643-2379 (Canada and USA), 1-519-888-4440, or reb@uwaterloo.ca.

For all other questions contact Elena Neiterman at eneiterman@uwaterloo.ca.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

□YES □NO

I agree to have my interview audio and video recorded.

□YES □NO

I agree to the use of anonymous quotations in the project papers and any other publications base on this research.

□YES □NO

Participant Name: _____ (Please print)

Participant Signature: _____ Date: _____

Researcher's/Witness' signature_____ Date:_____

Appendix G
Oral Consent Script

Hello. My name is Tanveer Randhawa and I am conducting research about immigrant Punjabi women's experiences with menopause. This interview is part of my Master's studies with the School of Public Health Sciences at the University of Waterloo. I'm working under the supervision of Dr. Elena Neiterman who are also part of the School of Public Health Sciences.

Thank you for your interest in participating in my research.

[If the LOI was provided in advance] Have you had time to read the Letter of Information I sent you?

[If the LOI was provided in advance and the participant responds that they have read the LOI] Great, then I would like to take a moment to review some main points from the Letter of Information before we continue. [Proceed to review the highlights of the LOI, including the risks and what will happen with their data, and confirm the important points about voluntary participation and withdrawal listed below.]

[If it is not possible to give an LOI to the participant, or if the LOI was not sent in advance, or the participant responds that they did not read the LOI in advance, then proceed to go through the full LOI in detail with the participant and confirm the important points about voluntary participation and withdrawal listed below.]

Confirm the following to the participant:

- Your participation in this study is voluntary.
- If you do not want to answer some of the questions you do not have to, but you can still be in the study.
- You can decide to stop at any time, even part-way through the interview for whatever reason.
- If you decide to stop during the interview, we will ask you how you would like us to handle the data collected up to that point, whether returning it to you, destroying it or using the data collected up to that point.

- You can ask to remove your data from the study up until approximately June 2025.
- This study has been reviewed and received ethics cleared through a University of Waterloo Research Ethics Board.
- By agreeing to participate in the study, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

Do you have any questions or want me to go over any study details again?

Consent questions:

1. Do you agree of your own free will, to participate in this study?
2. Do you agree to have your interview audio and, if applicable, video recorded?
3. Do you agree to the use of anonymous quotations in the thesis and any other publications based on this research?
4. Do you agree to the use of anonymized excerpts from your interview in the thesis and any other publications based on this research?

If no, “Thank you for your time.”

Appendix H
Interview Guide

Preface: [Share some information about myself first]. I'm interested in hearing about your experience with menopause, whether or not you have started this stage of life yet. Do you have any thoughts, perceptions, or experiences related to menopause? I'd like to understand how you've navigated this phase - whether that involves physical changes you've noticed or how you've sought support, whether from family, healthcare providers, or other sources. Think of sharing your story as if you were telling me about your journey. I want to learn about the different parts of your story, including any challenges you've faced and what has been helpful, how you've managed symptoms, and how this stage has affected you personally. You're welcome to share as much or as little as you're comfortable with. I have prepared some questions to help guide our conversation, but I'll also ask follow-up questions for clarification if needed. I'll be taking notes during our conversation today to help me understand your experience better, and I might paraphrase what you share with me to ensure I'm capturing your thoughts correctly. Please feel free to correct me if something doesn't sound right. My goal is to truly understand your thoughts and feelings about this experience, and I want to make this conversation comfortable and open, in a judgment-free environment.

Background and Personal Story

1. Can you tell me a bit about yourself?
    a. Prompt if needed: This could include your family background, what brought you to Canada, and what you enjoy doing.

Overall Health and Well-being

2. How have you noticed your health changing over the past year? How about your overall sense of well-being?
    a. Probe: Have you noticed any changes that you think might be related to getting older, or the aging process?
    b. Probe: Have you noticed any changes that you think might be connected to menopause?

c. Probe: Are there specific aspects of your physical or mental health that feel different compared to previous years?

d. Probe: How do you think these changes have influenced your daily life or routines?

Understanding and Experiences of Menopause

3. If you have started menopause, how have you experienced it so far?

    a. Probe: What physical or emotional changes have you noticed? How have they impacted your daily life?

4. Can you give an example of any symptoms you've experienced?

    a. Probe: Hot flashes, sleep disruptions, mood changes, or other sensations?

5. If you have not started menopause, how have you navigated this stage of life in preparation for menopause?

    a. Probe: What do you know or have heard about menopause? How do you feel about the changes that may come with it?

Cultural and Social Perspectives

6. How do you think menopause is understood or viewed in your culture or family?

    a. Probe: Are there any beliefs or expectations around this stage of life within your family?

    b. Probe: Are there any beliefs or expectations around this stage of life within your community?

7. Do you talk to others about menopause, your menopausal journey, or day-to-day experiences with it (menopause)? If so, who do you talk to, and how do they respond?

    a. Probe: Are these conversations easy to have, do they feel challenging, or something else?

Health-Seeking Behavior and Support Systems

8. How have you sought or received support for managing menopause symptoms? Could you describe this support?

a. Probe: Have you visited a doctor or consulted any healthcare provider for menopause-related issues?

9. How do you rely on support systems, such as friends, family, or community resources?
    a. Probe: How have these people or resources been helpful?
    b. Probe: What more would you like to have?

Healthcare Access and Cultural Humility

10. How have you generally experienced healthcare in Canada?
    a. Probe: Did you feel your concerns were understood and addressed?
11. How has the experience with menopause been similar to or different from other healthcare experiences you've had?
    a. Probe: Did you feel your concerns were understood and addressed?
12. Can you give an example of when you felt your cultural background was acknowledged (or not) in a healthcare setting?
    a. Prompt: This could be in terms of language, culture, or personal values.

Coping Strategies and Self-Care

13. How do you manage menopause symptoms, such as hot flashes, mood swings, or sleep disturbances?
    a. Probe: Are there any practices, routines, or remedies that you find helpful?

Impact on Identity and Role

14. Can you think if there are any ways in which menopause has affected who you are or your role within your family or community?
    a. Probe: Has this experience changed how you see yourself, or how others see you?

Social Stigma and Taboos

15. How do you feel about any cultural practices that are associated with menopause?

a. Probe: Stigma or taboo associated with menopause within your community, culture or upbringing?

b. Probe: Are they overall positive, negative, or neutral in your experience?

c. Probe: Are there any topics around menopause that are particularly difficult to discuss?

Reproductive Health in the Past Year

16. What healthcare experiences or interactions have you had in the past year related to gynecological health? How was your experience during those visits?

    a. Probe: How have these experiences impacted your well-being?

    b. Probe: How have they influenced your approach to managing your health at this stage of life based on your personal health needs?

Advice for Healthcare Providers

17. If you could give advice to healthcare providers about supporting South Asian or Punjabi women, going through menopause, what would you tell them?

    a. Prompt: This could be anything from understanding cultural sensitivities to specific practices.

Demographics:

Preface: If you are comfortable sharing, I have some demographic questions I would like to ask you. These are asked to help get a better idea of how who you are may have affected the way in which you experienced menopause or accessed healthcare services, and ultimately the care you received. If you would like to not answer a question, you can respond with, "prefer not to say."

18. We're almost done, and I was wondering if you could answer a few demographic questions for me.

    a. Can you please tell me your age?

    b. What year did you move to Canada?

    c. What is your highest level of education?

d. What is your family status?

    i. Probe: Are you currently married?

    ii. Probe: Do you have any children? If so, how many and how old are they?

Additional Thoughts:

19. Is there anything you feel that is important to share that we haven't already talked about?

Appendix I
Feedback Letter

Dear Participant,

I would like to thank you for your participation in this study entitled *Exploring Menopause Through a Cultural Lens: Beliefs, Perceptions, and Experiences of Immigrant Punjabi Women in the Peel Region*. I greatly appreciate the time and energy you put into the interview. I know that for some people it can be a vulnerable and even stigmatized topic and so value your willingness to share your journey with me.

As a reminder, the purpose of this study is to designed to deepen the understanding of the unique experiences of South Asian Punjabi immigrant women navigating menopause. This research aims to explore how cultural beliefs, social norms, and migration challenges shape their perceptions and management of menopause, with the goal of informing culturally responsive and equitable healthcare practices. This study has been reviewed by and received ethics clearance through a University of Waterloo Research Ethics Board (ORE# 47078). If you have questions for the Board, please contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or reb@uwaterloo.ca. For all other questions, please contact my supervisor, Dr. Elena Neiterman at (519) 888- 4567 ext. 48221, eneiterman@uwaterloo.ca .

Please remember that your identity will be kept confidential. The audio and video record of your interview will be deleted after transcription is completed. Any paper records of data collected during this study will be retained for a minimum of 7 years in a locked filing cabinet, to which only I will have access. Electronic data will be kept for a minimum of 7 years on a secure computer, to which only researchers associated with this study have access. All identifying information will be removed from the records prior to storage. You can withdraw your consent to participate and request to have your data destroyed at any time during data collection and analysis. You will not be able to withdraw consent once the final project paper has been submitted or findings are shared with the public, which will occur in approximately May 2025.

Once all the data are collected and analyzed for this project, I will present the findings as a thesis research project and may also share this information with the research community through

seminars, conferences, presentations, policy briefs and reports, and journal articles. The expected completion date of my final research project report is August 2025. If you would like to read my report, I would be happy to send it to you. Please provide your email or mailing address and, when the study is completed, I will send you the information.

In the meantime, if you have any questions about the study, please do not hesitate to contact me or Dr. Neiterman.

Kindly,

Tanveer Randhawa, BSc

Student-Researcher, MSc Candidate in the School of Public Health Sciences

University of Waterloo LHN 3721, 200 University Ave West Waterloo, ON N2L 3G1

Email: tkrandha@uwaterloo.ca

Appendix J

Coding Diagram

<table>
<tr>
<td rowspan="5">Experiences, thoughts, perceptions of menopause at the intersect of culture, immigration, and the Canadian Healthcare system</td>
<td rowspan="2">Managing Menopause Through Culture & Familial Practice</td>
<td>• Herbs
• Home remedies
• Turmeric
• Yoga
• Squash</td>
<td rowspan="5">• Cultural norms affect health-seeking behaviour and promote secrecy
• Gendered roles limit support
• Traditional knowledge became a resource and a constraint
• Immigration allowed for open conversations
• Gaps in generational knowledge about menopause</td>
</tr>
<tr>
<td>• Support
• Lack of support
• Family Support
• Husbands
• Children
• Elders</td>
</tr>
<tr>
<td rowspan="2">Cultural Silence and Stigma Surrounding Menopause</td>
<td>• Shame
• Embarrassment
• Silence
• Whispering
• Shush, ‘shh’</td>
</tr>
<tr>
<td>• Lack of open dialogue
• Lack of conversations
• Lack of health literacy</td>
</tr>
<tr>
<td>Navigating and Accessing the Canadian Healthcare System</td>
<td>• Misdiagnosis
• ‘In your head’
• Dismissal by doctors
• Rude behaviour</td>
</tr>
</table>

		• Low quality of care	
		• Cultural barriers to access • Accessing resources as an immigrant • No agency • Confusion with the healthcare system	

Appendix K

Themes and Subthemes Diagram

4.1 Embodiment of Menopause in Everyday Life	4.1.1 Discovery of Symptoms
	4.1.2 Learning on the Go: Lack of Information
	4.1.3 Embodied Stress and Gendered Experience
4.2. Pathways to Seeking Care and Knowledge	4.2.1 Learning About Menopause
	4.2.2 Western Medicine
	4.2.3 Home Remedies and Self-Care
	4.2.4 Building a Community of Care
4.3. Breaking the Silence	4.3.1 Finding a Voice Within: Self-Discovery and Wisdom
	4.3.2 Shifting Cultural Echoes: Immigration as a Key Factor
	4.3.3 Speaking Forward: Breaking Generational Silence and Advice for Providers