Structured Research Question

Assignment 2

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AHS 6000: Introduction to Health Services Research

Creating a Structured Problem Statement

Knowledge Gaps in Menopause

The health problem I would prioritize involves knowledge gaps about menopause, with the core problem being a widespread lack of awareness compounded by societal stigma. This combination often leads to the normalization and under-recognition of symptoms. Improving health literacy directly addresses these challenges and is essential for empowering women to understand their experiences, seek appropriate help, and advocate for better care (Zahn et al., 2024).

The goal of this research is to assess the feasibility, acceptability, and impact of a co-designed menopause peer support program. It will evaluate how effectively the program improves psychosocial well-being and health literacy among menopausal women. Both quantitative data and qualitative insights will be collected to ensure an evidence-based, inclusive, and scalable approach. Menopause peer support involves structured, community-based mutual emotional and informational support led by those with lived experience. These communities share knowledge to enhance health literacy and support informed decisions for well-being.

The study will employ a mixed-methods pilot study in three phases, guided by principles that are patient-engaged, equity-focused, and trauma-informed. A Patient Advisory Group (PAG) will co-design both the peer support groups and the facilitator training curriculum. Quantitative data will measure participant outcomes and training effectiveness, while qualitative data will capture lived experiences, perceived benefits, and contextual factors. As a pilot, this study will focus on preliminary testing to inform future larger-scale implementation.

Specifically, the study’s objectives are as follows:

1. Co-design a menopause peer support program incorporating women's lived experiences and evidence-based methods.

2. Develop and deliver a structured training program for peer support facilitators who have experienced menopause themselves.

3. Pilot the peer support group intervention and evaluate its feasibility, acceptability, and perceived impact.

4. Enhance patient engagement in health services research by focusing on participant expertise in a model that can be replicated.

By achieving these objectives, the project expects to generate insights across four key domains. Each research phase will build upon the previous one to co-design, test, and refine a scalable menopause peer support model that can be adapted for broader implementation.

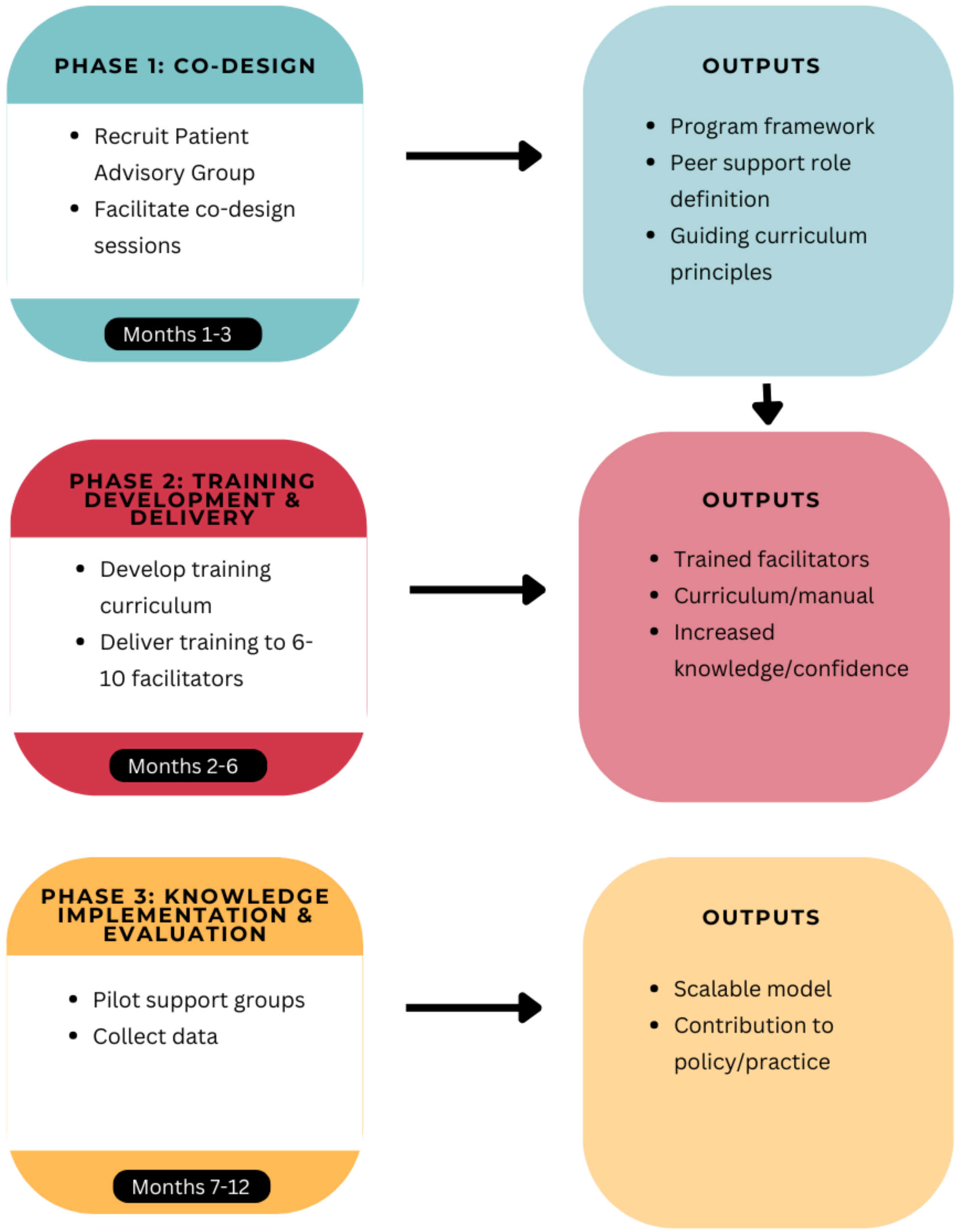
Research Approach and Design

The research will use a mixed-methods, patient-engaged pilot study design. This is appropriate because the project aims to evaluate both measurable outcomes, such as improvements in health literacy and psychosocial well-being, as well as participants' lived experiences. These experiences include their sense of support and belonging. By integrating both, the study will provide a comprehensive understanding of the program's feasibility, acceptability, and potential impact. Women with lived experience of menopause, through the Patient Advisory Group, will shape the design of the peer support groups and the facilitator training curriculum. This ensures the research process centers participants as experts in their own care. As a pilot study, the research focuses on preliminary testing of the intervention to inform a larger-scale rollout.

Research Flow

Menopause Peer Support Program

RESEARCH FLOW AND EVALUATION



PHASE 1: CO-DESIGN

- Recruit Patient Advisory Group
- Facilitate co-design sessions

Months 1-3

OUTPUTS

- Program framework
- Peer support role definition
- Guiding curriculum principles

PHASE 2: TRAINING DEVELOPMENT & DELIVERY

- Develop training curriculum
- Deliver training to 6-10 facilitators

Months 2-6

OUTPUTS

- Trained facilitators
- Curriculum/manual
- Increased knowledge/confidence

PHASE 3: KNOWLEDGE IMPLEMENTATION & EVALUATION

- Pilot support groups
- Collect data

Months 7-12

OUTPUTS

- Scalable model
- Contribution to policy/practice

KNOWLEDGE TRANSLATION

Organization of the Research and Data Collection

Phase 1: Co-Design (Months 1–3). The Patient Advisory Group will engage in two to three workshops and story-sharing sessions to collaboratively co-design the peer support program. This participatory process will produce a program framework with clearly defined peer supporter roles and embed menopause health literacy to guide curriculum development. Insights drawn from qualitative discussions and participant surveys will ensure that the model is responsive to the lived experiences and needs of menopausal women.

Phase 2: Facilitator Training (Months 2–6). Six to ten peer facilitators will complete a five-week virtual training. Pre- and post-training surveys and feedback forms will measure changes in knowledge, confidence, and preparedness in peer support skills, health literacy, and boundary setting.

Phase 3: Pilot Implementation (Months 7–10). Three to five support groups (each with 8–12 participants) will be piloted, involving 30–40 participants. The data will include attendance and retention rates, as well as pre- and post-surveys on menopause health literacy and psychosocial well-being, and qualitative reflections from participants and facilitators.

Phase 4: Knowledge Generation (Months 10–18). A mixed-methods analysis will combine descriptive statistics and thematic analysis to evaluate the feasibility, acceptability, and preliminary outcomes. Findings will be translated into an open-access toolkit and disseminated through academic channels, policy briefs, and community health organizations to facilitate adaptation and broader implementation.

Anticipated study findings include a measurable reduction in psychosocial distress, assessed by the Menopause-Specific Quality of Life (MENQOL) questionnaire, and an increase in menopause health literacy among participants. Participants are also expected to report a stronger sense of belonging and reduced isolation. The study will assess the practicality of delivering virtual peer support, offering guidance for future program development.

Contribution to Knowledge

This approach builds knowledge across domains. It enables a co-designed, scalable menopause peer support model tailored for diverse populations, including rural, Indigenous, and gender-diverse individuals. It provides an open-access, evidence-based facilitator training curriculum based on adult learning theory. The mixed-methods evaluation generates robust evidence on the feasibility, acceptability, and outcomes for participants. By centering lived experience, the study advances patient engagement methods and offers a replicable model for community-based interventions in women's health, informing policy and practice.

Participant Selection: Menopause Peer Support Program

Group	Sample Size & Timing	Eligibility/Criteria	Role in Study	Recruitment Approach
Patient Advisory Group (PAG)	6–8 women (Phase 1: Months 1–3)	Lived menopause experience; diverse age, cultural background, symptom experiences, plus subject matter experts in peer support and HCPs providing menopausal care	Co-design program model, peer supporter roles, and guiding curriculum principles	Purposive sampling; outreach via women's health organizations, community health boards, and local networks
Peer Facilitators	6–10 individuals (Phase 2: Months 5–6)	Must have lived menopause experience; aim for diversity (Indigenous, rural, gender-diverse participants)	Complete five-week training program; facilitate support groups	Purposive recruitment, emphasizing inclusivity and scalability
Support Group Participants	30–40 participants across 3–5 groups (Phase 3: Months 7–9)	Menopausal individuals; initial focus on Canadian women aged 45–55, inclusive of diverse gender identities	Participate in peer support groups; provide data through surveys and interviews	Recruitment via health/community organizations; online & hybrid access for rural/underserved groups

Data Collection Methods

Patient Advisory Group (Phase 1). Co-design workshops, story-sharing sessions, and reflective discussions will be used. Data collection will involve taking notes, making recordings, and conducting thematic analysis. These will capture qualitative insights on menopause experiences, support needs, and health literacy priorities.

Peer Facilitators (Phase 2). Pre- and post-training surveys will assess changes in knowledge of menopause, facilitation confidence, and preparedness. At the end of training, short reflective interviews will gather additional feedback.

Support Group Participants (Phase 3). Data will be collected through a mixed-methods approach.

Quantitative: Standardized pre- and post-program surveys will be used. These include the Psychosocial Domain of the MENQOL instrument. The measured outcomes will include changes in emotional distress, social connectedness, and psychosocial well-being. The expected result is a measurable reduction in psychosocial symptoms and emotional distress among menopausal women.

Qualitative: Semi-structured interviews and focus groups will explore participant experiences, sense of belonging, and program acceptability.

This approach builds upon findings from Cowell et al. (2024), who demonstrated that peer support groups are effective because they offer emotional support, reduce isolation, foster open discussions, and ultimately enhance mental health and quality of life.

References

Cowell, A. C., Gilmour, A., & Atkinson, D. (2024). Support mechanisms for women during menopause: Perspectives from social and professional structures. *Women, 4*(1), 53–72. https://doi.org/10.3390/women4010005

Zahn, K., Pittman, A., Conklin, J., Knittel, A., & Neal-Perry, G. (2024). *Disparities in menopausal care in the United States: A systematic review. Maturitas, 186,* 108021. https://doi.org/10.1016/j.maturitas.2024.108021