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# BETWEEN STIGMA AND SUPPORT: HOW SOCIO-CULTURAL NORMS SHAPE HEALTH DECISIONS AMONG PERIMENOPAUSAL WOMEN IN BAYELSA CENTRAL, NIGERIA

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## ABSTRACT
*This study explores how socio-cultural norms, stigma, and support systems shape the health-seeking behaviours of perimenopausal women within universities in Bayelsa Central, Nigeria. Using a mixed-methods approach, data were collected from 313 female staff through structured questionnaires and in-depth interviews. Quantitative results revealed that only a minority of respondents seek professional healthcare for perimenopausal symptoms, with a preference for faith-based and traditional providers. Age, education, income, and staff category were significantly associated with health-seeking behaviour ($p < 0.001$). Cultural beliefs were influential, with 47.3% of women reporting experiences of stigma and 31.6% keeping menopause entirely private. Openness in discussing menopause, comfort with healthcare providers, and expectations of culturally sensitive care were strong predictors of professional healthcare use. Qualitative findings highlight that cultural silence, myths, and lack of provider empathy discourage timely medical engagement. However, supportive environments and cultural sensitivity among providers enhanced positive health behaviours. The study concluded that despite high levels of education and employment, cultural norms continue to mediate access to care. Policy responses must prioritize culturally responsive healthcare, stigma reduction, and institutional support for midlife women. Addressing these gaps will improve the quality of care and health outcomes for women navigating perimenopause in similar socio-cultural contexts.*

***Keywords**: Perimenopause, Health-seeking behaviour, Socio-cultural norms, Stigma and support, Women's health in Nigeria*

## INTRODUCTION
Perimenopause represents a transitional phase in a woman's reproductive life, marked by hormonal changes and symptoms such as irregular menstruation, hot flashes, fatigue, and mood fluctuations (Hagos, 2022; Hayfield & Campbell, 2022). While these biological symptoms are universal, the ways women understand, interpret, and respond to them are deeply shaped by socio-cultural contexts (Obeagu, 2025). In many African societies, including Nigeria, menopause is not simply a physiological event, it is a social experience mediated by cultural norms, religious beliefs, traditional health practices, and gendered expectations (Anuforo, Oyedele & Anuforo, 2025; Blount, 2021).

Cultural narratives frequently portray menopause as a sign of aging and declining womanhood, thereby discouraging open discussion and engagement with healthcare systems (Ejidike, 2022; Zou, Zhang & Wang, 2022). As a result, many women experience shame, fear of judgment, or social invisibility, which undermines their willingness to seek care. As MacLellan, Green and Kennedy (2023) observed, menopausal transitions are often managed privately or through non-professional channels, especially when cultural norms restrict public discourse around reproductive health. Even in professional environments such as academic institutions, the issue remains largely unaddressed, and perimenopause continues to be surrounded by silence and stigma.

In the Nigerian context, particularly in the Niger Delta region, traditional and spiritual is beliefs remain potent forces in shaping health behaviours (Michael, Nwokocha & Agbana, 2023). Studies have shown that many women interpret perimenopausal symptoms as spiritual afflictions or signs of moral imbalance, leading them to seek healing from religious or traditional healers rather than medical professionals (Olowokere, Adeleke & Idowu, 2021; Aliyu, Ibrahim & Adamu,

2025). This preference is often reinforced by the limited cultural sensitivity of formal health systems, where providers may be inadequately trained to address midlife women's health in a contextually relevant manner (Jahangirifar, Malek & Montazeri, 2023; Hayford, 2023).

Although research on menopause is expanding globally, it remains underexplored in sub-Saharan Africa and particularly in institutional spaces where women are assumed to have better access to health information. Recent studies (e.g., Demehin & Isiugo-Abanihe, 2024; Nguyen, 2023) emphasize the importance of understanding menopause not just as a biomedical condition, but as a socio-cultural phenomenon shaped by class, education, marital status, and cultural beliefs. However, few studies have examined how these dynamics unfold among educated women within Nigerian universities—spaces that both reinforce and challenge traditional gender norms.

This study addresses this gap by exploring the dual role of stigma and support in shaping health-seeking behaviours among perimenopausal women employed in universities in Bayelsa Central, Nigeria. Drawing on a mixed-method approach and guided by the Health Belief Model and Symbolic Interactionism, the study investigates how women's perceptions, cultural conditioning, and social networks influence their decisions to engage with professional or non-professional health services. In doing so, it aims to generate context-specific evidence to inform culturally responsive and gender-sensitive healthcare interventions for midlife women.

## THEORETICAL FRAMEWORK

This study is anchored on the Health Belief Model (HBM) and complemented by Symbolic Interactionism Theory to provide a robust lens through which to examine how socio-cultural norms, manifesting as both stigma and support, influence the health decisions of perimenopausal women in Bayelsa Central, Nigeria.

The Health Belief Model, developed by Hochbaum, Rosenstock, and Kegels in the 1950s, is a psychological model that explains and predicts health behaviours by focusing on individuals' beliefs about health conditions and their decisions to act (or not act). The model posits that health-seeking behaviour is determined by six key constructs:

- Perceived Susceptibility: An individual's belief about the likelihood of experiencing a health problem. For perimenopausal women, those who believe they are vulnerable to complications during this phase may be more likely to seek care.
- Perceived Severity: The belief about the seriousness of a health condition and its potential consequences. Women who associate perimenopausal symptoms with serious health risks may engage in more proactive health-seeking behaviour.
- Perceived Benefits: The belief that a specific health action will reduce the threat or improve well-being. For instance, believing that consulting a health professional will relieve menopausal symptoms may encourage formal care-seeking.
- Perceived Barriers: Factors that hinder the adoption of health behaviours. These may include cultural stigma, cost of care, fear of judgment, or limited access to female health providers.
- Cues to Action: External or internal stimuli that prompt decision-making. These could include experiencing worsening symptoms, media messages, or advice from peers or health campaigns.
- Self-Efficacy: The confidence in one's ability to successfully undertake a health-seeking action. Women with greater knowledge and empowerment are more likely to overcome social stigma and pursue needed care.

In the context of this study, the HBM helps illuminate how women weigh their perceived risks and benefits against cultural and structural barriers, shaping their choices to engage in modern, traditional, or hybrid health practices.

To further interpret how socio-cultural meanings influence behaviour, this study also draws from Symbolic Interactionism, a sociological framework advanced by George Herbert Mead and

Herbert Blumer. This theory emphasizes the role of symbols, language, and meaning in shaping human interactions and behaviours. Applied to the context of perimenopause:

- The meaning attached to menopause (e.g., as a sign of aging, infertility, or loss of femininity) is socially constructed and varies across cultural groups.
- Stigmatizing labels, such as being "past one's prime" or "unfit for productivity," influence how women perceive their bodies and whether they feel empowered or ashamed to seek help.
- Support systems, such as peer groups or communal associations, provide alternative symbols of resilience, solidarity, and health affirmation that can counter negative stereotypes and encourage care-seeking.

This theory is particularly useful in unpacking how interactions with peers, family, and healthcare providers reinforce or challenge dominant narratives around perimenopause, and how these interactions shape women's internalized beliefs and outward behaviours.

Together, the HBM and Symbolic Interactionism provide a multidimensional framework for understanding perimenopausal women's health decisions. While HBM identifies individual-level motivators and deterrents to seeking care, Symbolic Interactionism situates those decisions within the broader social meanings, labels, and cultural expectations that mediate their choices. This theoretical duality helps the study capture both rational decision-making processes and socially embedded experiences, essential for comprehending how stigma and support simultaneously shape health behaviours in a Nigerian university context.

## METHODOLOGY

### Research Design

This study employed a mixed-methods, cross-sectional design to explore how socio-cultural norms, specifically stigma and support structures, shape the health-seeking behaviours of perimenopausal women within university settings in Bayelsa Central, Nigeria. The integration of both quantitative and qualitative approaches provided a comprehensive understanding of not only the patterns of behaviour but also the underlying motivations, meanings, and socio-cultural influences driving these behaviours. The quantitative component utilized a structured questionnaire to collect standardized data from a larger group of respondents, allowing for descriptive analysis of health-seeking patterns and perceptions. The qualitative component involved in-depth interviews (IDIs) with a purposively selected subset of participants to gain nuanced insights into personal experiences, cultural interpretations, and emotional responses associated with perimenopausal health and care decisions.

### Study Area

The study was conducted in Bayelsa Central Senatorial District, with a specific focus on two public universities: Niger Delta University (NDU) in Amassoma and Bayelsa Medical University (BMU) in Yenagoa. These institutions represent a mix of academic and non-academic populations and are situated within diverse socio-cultural settings reflective of the broader Ijaw communities of the Niger Delta. The universities were selected due to their accessibility, concentration of educated female staff, and unique institutional dynamics that may influence health-seeking behaviour.

### Study Population

The target population comprised female staff (both teaching and non-teaching) within the perimenopausal age range (approximately 40–55 years) who were employed at the two selected universities. This demographic was chosen based on their likelihood of experiencing perimenopausal symptoms and their exposure to both formal health systems and socio-cultural influences.

### Sampling and Sample Size

A multistage sampling approach was adopted to ensure representativeness and contextual relevance. First, Niger Delta University (NDU) and Bayelsa Medical University (BMU) were purposively selected based on their location within Bayelsa Central Senatorial District and their status as major public institutions employing a substantial number of female staff within the perimenopausal age range. These universities provided a diverse population of academic and non-academic female staff, making them suitable for exploring variations in health-seeking behaviour and socio-cultural experiences within an institutional setting. Within each selected university, stratified sampling was employed to capture proportional representation from the two main staff categories—academic and non-academic staff—ensuring variability in occupational exposure, education levels, and socio-economic status. Within each stratum (academic and non-academic), participants were then selected using simple random sampling techniques, where every eligible respondent had an equal chance of selection. This approach minimized selection bias and improved the generalizability of findings within each institutional context. For the qualitative interviews, 34 participants (20 from NDU and 14 from BMU) were purposively selected based on their unique responses to the survey, with consideration for variation in age, department, symptom severity, and reported health-seeking behaviour. This allowed for diversity in perspectives and ensured data saturation.

**Instruments for Data Collection**

The instruments for data collection included both quantitative and qualitative tools. For the quantitative component, a structured and pre-tested questionnaire was used to gather information on socio-demographic characteristics, perceived perimenopausal symptoms, health-seeking behaviour (both formal and informal), cultural beliefs and attitudes toward menopause, as well as experiences of stigma or support from family, colleagues, and the community. For the qualitative component, an in-depth interview guide was developed to explore personal narratives of perimenopausal transition, perceived cultural meanings of menopause, sources of emotional or social support, encounters with stigma or silence, and the dynamics of decision-making around healthcare utilization. Both instruments were validated through expert review and piloted with a small group of respondents before full implementation to ensure clarity, relevance, and reliability.

**Method of Data Collection**

Quantitative data were collected by the principal researcher and trained research assistants using paper-based questionnaires during scheduled visits to the universities. Respondents were assured of confidentiality and encouraged to respond truthfully. The qualitative interviews were conducted in private, convenient settings, mostly in office spaces or quiet campus areas, and lasted approximately 45–60 minutes each. All interviews were audio-recorded (with consent), transcribed verbatim, and translated into English where necessary.

**Data Analysis**

Quantitative data were entered into SPSS Version 27 for cleaning and analysis. Descriptive statistics (frequencies, percentages, means) were used to summarize demographic characteristics, symptom experiences, and health-seeking patterns. Qualitative data were analysed thematically using a manual coding approach. Transcripts were read multiple times to identify key patterns and recurring ideas. Codes were grouped into themes such as “cultural interpretations of menopause,” “supportive versus stigmatizing environments,” and “navigating traditional and formal care.” ATLAS.ti software was used to assist with data organization and retrieval.

**Ethical Considerations**

Institutional permissions were secured from both universities. Participants provided informed consent prior to inclusion in the study. Confidentiality and anonymity were strictly upheld, and

participants were informed of their right to withdraw from the study at any time without consequence.

## RESULTS

### Sample Characteristics

Out of 334 questionnaires distributed, a total of 313 valid responses were analyzed, representing a 93.7% response rate. The majority of respondents (63.3%) were aged between 45 and 49 years, indicative of mid-stage perimenopause, while 20.1% were under 44 years, and 16.6% were 50 years or older. A good number of respondents possessed tertiary-level education, with 38.0% holding a Bachelor's degree or Higher National Diploma (HND), and 15.3% having postgraduate qualifications. Additionally, 31.0% attained post-secondary education, which likely includes diplomas and professional certifications. Only 15.7% had a secondary education or lower, indicating that the sample was relatively educated. A significant proportion of participants (71.2%) were married, and 81.8% identified as Ijaw and from Bayelsa State. The sample comprised primarily Christian respondents (94.6%), with most earning between ₦100,000 and ₦199,999 monthly (64.2%). Notably, the distribution favoured non-academic staff (76%), and the sample was predominantly drawn from Niger Delta University (89.8%).

### Healthcare Facility Preferences

The most consulted healthcare option among perimenopausal women was faith-based centres (32.1%), followed by traditional healers (24.5%), private hospitals (22.2%), and government hospitals (21.2%). (Figure 1).

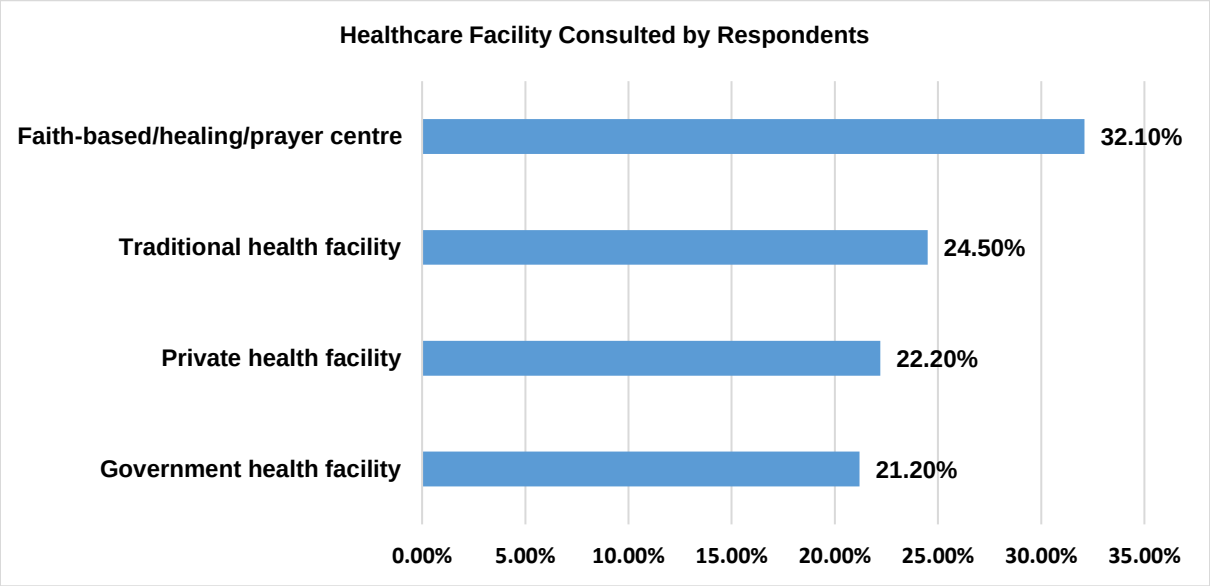


***Figure 1: Percentage Distribution of Healthcare Facility Consulted by Respondents***

Qualitative data corroborated this preference, with respondents citing spiritual significance, cultural familiarity, and quicker attention at non-public institutions as reasons for their choices:

> *"I use traditional birth attendants and herbal clinics because they understand women's health better." [Respondent 017, BMU, Age 50]*

### Socio-Demographic Associations with Health-Seeking Behaviour

Chi-square tests revealed statistically significant associations between health-seeking behaviour and several socio-demographic factors (Table 1). The results show that younger women (<44 years) were more likely to seek professional care (76.2%) compared to those aged 50+ (17.3%) ($p < 0.001$). Professional healthcare-seeking increased with educational level, from 44.9% among those with secondary or less to 83.3% among postgraduates ($p < 0.001$). Married women had higher professional care use (71.3%) than singles and divorced/separated women ($p < 0.001$). Academic (84%) and senior non-academic staff (80.8%) predominantly used professional care, unlike junior staff (38.1%) ($p < 0.001$). Higher income correlated with professional healthcare-seeking; 91.1% of those earning ₦200,000+ sought formal care versus 20.0% among those earning below ₦99,999 ($p < 0.001$). University, state of origin, ethnicity, and religion did not show statistically significant associations, though cultural patterns emerged in qualitative responses.

**Table 1: Chi-square Analysis showing association socio-demographics and health-seeking behaviour among perimenopausal women**

| Variable | Health-Seeking Behaviour | | Total (n, %) | X2 | P-value |
|---|---|---|---|---|---|
| | Non-Professional (n, %) | Professional (n, %) | | | |
| **Age Group** | | | | | |
| Below 44 years | 15 (23.8%) | 48 (76.2%) | 63 (100%) | 160.731 | <0.001 |
| 45-49 years | 121 (61.1%) | 77 (38.9%) | 198 (100%) | | |
| 50+ | 43 (82.7%) | 9 (17.3%) | 52 (100%) | | |
| **Educational Level** | | | | | |
| Secondary or less | 27 (55.1%) | 22 (44.9%) | 49 (100%) | 23.04 | <0.001 |
| Post-secondary | 42 (43.3%) | 55 (56.7%) | 97 (100%) | | |
| Bachelors/HND | 31 (26.1%) | 88 (73.9%) | 119 (100%) | | |
| Postgraduate | 8 (16.7%) | 40 (83.3%) | 48 (100%) | | |
| **Marital Status** | | | | | |
| Single | 20 (60.6%) | 13 (39.4%) | 33 (100%) | 18.277 | <0.001 |
| Married | 64 (28.7%) | 159 (71.3%) | 223 (100%) | | |
| Divorced/Separated | 13 (56.5%) | 10 (43.5%) | 23 (100%) | | |
| Widowed | 11 (32.4%) | 23 (67.6%) | 34 (100%) | | |
| **University** | | | | | |
| Niger Delta University (NDU) | 102 (36.3%) | 179 (63.7%) | 281 (100%) | 3.915 | 0.058 |
| Bayelsa Medical University (BMU) | 6 (18.8%) | 26 (81.3%) | 32 (100%) | | |
| **Staff Categorization** | | | | | |
| Academic staff | 12 (16.0%) | 63 (84.0%) | 75 (100%) | 62.942 | <0.001 |
| Non-academic staff (senior) | 23 (19.2%) | 97 (80.8%) | 120 (100%) | | |
| Non-academic staff (Junior) | 73 (61.9%) | 45 (38.1%) | 118 (100%) | | |
| **State of Origin** | | | | | |
| Bayelsa | 95 (37.1%) | 161 (62.9%) | 256 (100%) | 4.22 | 0.051 |
| Non-Bayelsa | 13 (22.8%) | 44 (77.2%) | 57 (100%) | | |
| **Ethnic Group** | | | | | |
| Ijaw | 95 (37.1%) | 161 (62.9%) | 256 (100%) | 5.857 | 0.21 |
| Hausa | 2 (18.2%) | 9 (81.8%) | 11 (100%) | | |

| | | | | | |
|---|---|---|---|---|---|
| Yoruba | 5 (25.0%) | 15 (75.0%) | 20 (100%) | | |
| Igbo | 2 (13.3%) | 13 (86.7%) | 15 (100%) | | |
| Other | 4 (36.4%) | 7 (63.6%) | 11 (100%) | | |
| **Religion** | | | | | |
| Christianity | 105 (35.5%) | 191 (64.5%) | 296 (100%) | 2.261 | 0.133 |
| Islam | 3 (17.6%) | 14 (82.4%) | 17 (100%) | | |
| **Income** | | | | | |
| Less than N70,000 | 20 (64.5%) | 11 (35.5%) | 31 (100%) | 52.351 | <0.001 |
| N70,000-N99,999 | 20 (80.0%) | 5 (20.0%) | 25 (100%) | | |
| N100,000-N199,999 | 63 (31.3%) | 138 (68.7%) | 201 (100%) | | |
| N200,000 and above | 5 (8.9%) | 51 (91.1%) | 56 (100%) | | |

*Significant at $p < 0.05$*

## Cultural Perceptions and Health-Seeking Behaviour

Respondents' cultural beliefs about menopause strongly influenced their health decisions. While 30.7% viewed menopause as a natural life transition, 22.7% saw it as a private matter, and 18% described it as misunderstood or surrounded by stigma. These beliefs were significantly associated with health-seeking behaviour ($p < 0.001$), with those embracing menopause as natural more likely to pursue professional care (81.3%) compared to those perceiving it as stigmatized (37.5%). (Figure 2).

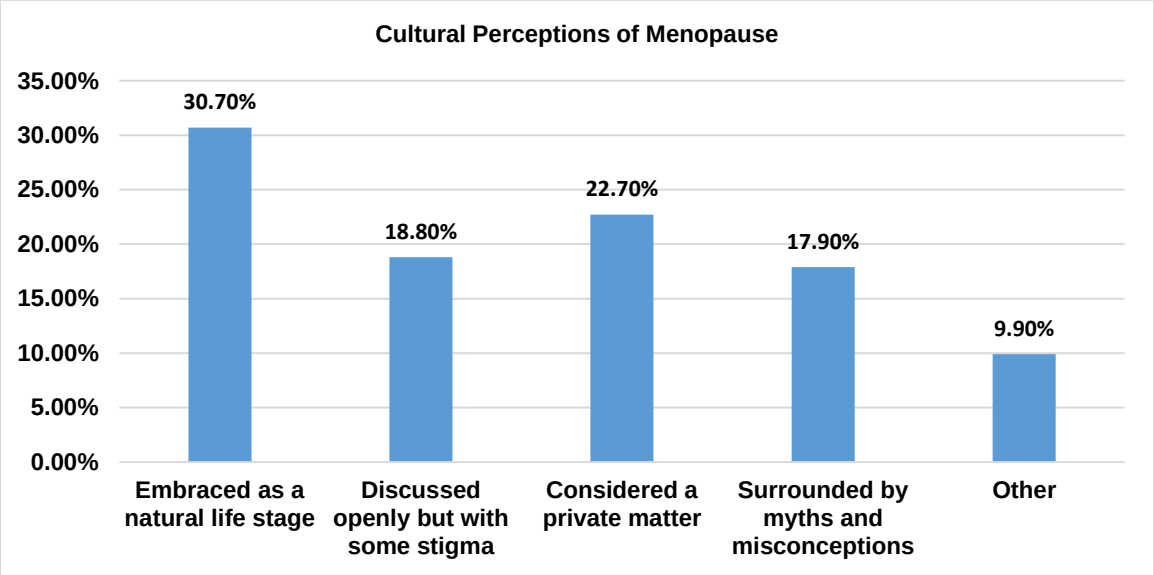


***Figure 2: Distribution of Respondents by Cultural Perceptions of Menopause***

Statements from the qualitative interviews also highlight a critical gap in health literacy among perimenopausal women regarding surgical menopause—the abrupt onset of menopausal symptoms following procedures such as hysterectomy or oophorectomy. The lack of awareness may lead to confusion, misattribution of symptoms to other causes, and delays in seeking appropriate medical care. It underscores the need for better pre- and post-operative counselling and public education to ensure women are informed about all possible pathways to menopause and how to manage them effectively. In the words of a participants:

> *"Many women do not know that medically, a woman can plunge into menopause after surgery..." [Respondent 002, BMU, Age 51]*

Interview statements further reflect a growing but still limited awareness among some women that natural (non-surgical) early menopause can occur, even before the commonly expected age range of late 40s to early 50s. Some respondents acknowledge that menopause can happen as early as age 40 without medical intervention, suggesting some level of understanding of premature or early menopause due to natural causes such as genetics, autoimmune conditions, or chronic illnesses. However, the tone also implies that this knowledge is not widespread, especially among peers.

> "*That a woman can naturally get to menopause even at 40 without surgery but due to natural causes..." [Respondent 003, NDU, Age 44]*

The quote emphasizes the need for more comprehensive health education about the different types and timing of menopause, so that women can recognize symptoms earlier, seek timely care, and avoid misinterpretations influenced by cultural or spiritual explanations.

**Openness and Communication on Menopause**

Only 20.8% of respondents felt comfortable discussing menopause openly. Most limited conversations to family (47.6%) or kept the matter entirely private (31.6%). Openness significantly correlated with professional care use ($p < 0.001$), suggesting that cultural silence may hinder timely health interventions. (Figure 3).

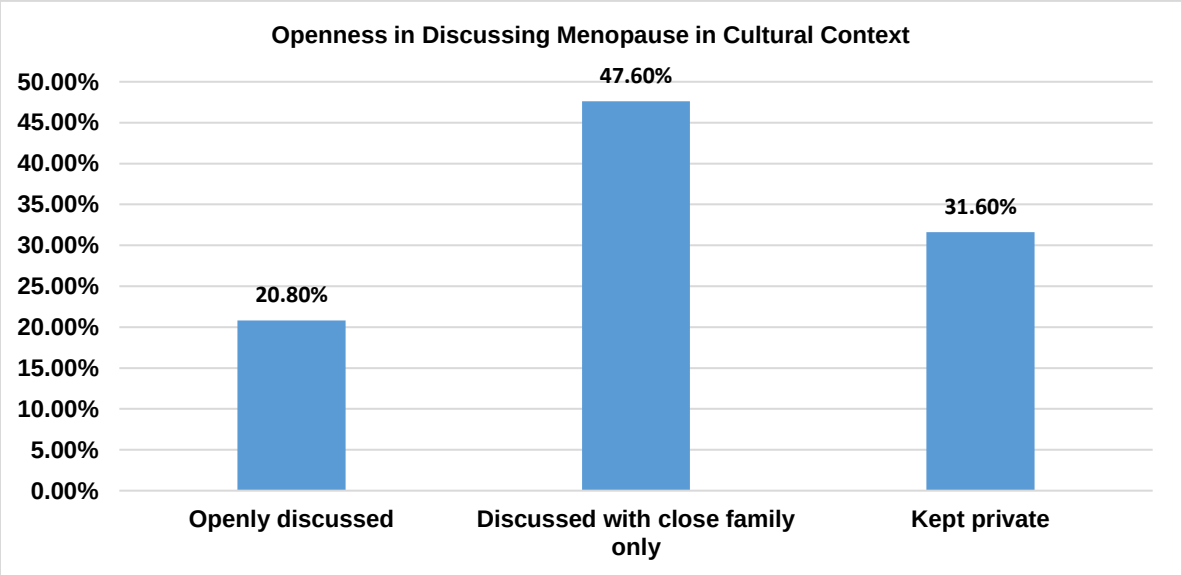


***Figure 3: Distribution of Respondents by Openness in Discussing Menopause in Cultural Context***

Qualitative statements also reflect the cultural norm of keeping menopause a private and family-bound issue, limiting open dialogue beyond close relatives as indicated by one of the respondents who stated thus:.

> *"I only discuss menopause with my husband and sisters. It is a personal matter." [Respondent 014, BMU, Age 48]*

The above response suggests that while the respondent has a small support network, the broader social silence around menopause may restrict access to diverse perspectives and professional advice. This selective openness can contribute to limited health-seeking behaviour, reinforce stigma, and reduce the likelihood of engaging with formal healthcare services for perimenopausal concerns.

**Cultural Attitudes, Stigma, and Healthcare Decisions**

A majority of respondents reported that cultural norms moderately (40.9%) or significantly (23.3%) influenced their healthcare decisions. As shown in Figure 4, nearly half (47.3%) had experienced

cultural stigma surrounding menopause, which strongly affected health-seeking behaviour ($p < 0.001$).

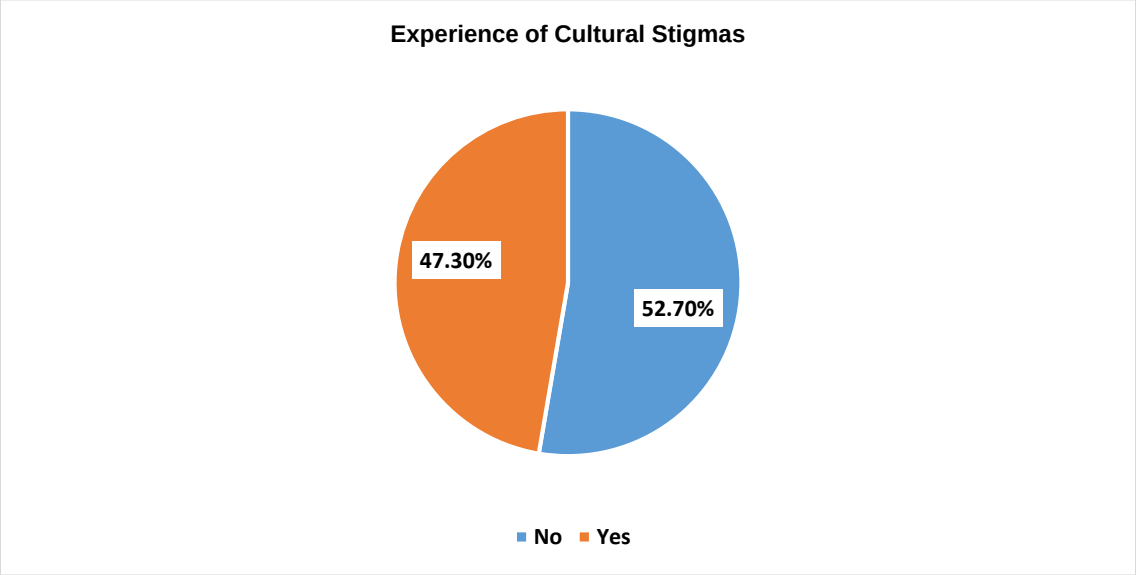


***Figure 4: Distribution of Respondents by Experience of Cultural Stigmas Regarding Perimenopause Experience***

The qualitative statements also reveal the deep-rooted cultural stigma surrounding menopause, where aging and the end of fertility are perceived as markers of decline, weakness, and social irrelevance. Such views reflect patriarchal norms that tie a woman's value to her reproductive ability and youth. This perception led to emotional distress, loss of self-worth, discomfort with healthcare providers, expectations of culturally sensitive care, and reluctance to seek healthcare, as women may internalize these negative societal attitudes. In the words of one of the participants:

> *"People think menopause makes a woman less useful. Some even say we become weak and irrelevant in society." [Respondent 027, NDU, Age 48]*

The above underscores the urgent need for cultural reorientation and public sensitization to affirm the dignity and continued worth of women beyond their reproductive years.

## DISCUSSION

The present study explored the influence of socio-cultural norms on the health-seeking behaviour of perimenopausal women within universities in Bayelsa Central, Nigeria. The findings confirm that cultural beliefs, income, education, and experiences of stigma significantly shape women's responses to perimenopausal health concerns. A key finding was the preference for non-professional care—such as traditional healers and faith-based centres—among a substantial number of respondents. This aligns with prior literature (e.g., Azar, Sadat & Fathi-Ashtiani, 2021; Olowokere et al., 2021) which highlights the enduring role of traditional beliefs and practices in shaping women's health choices. The dominance of Ijaw culture and Christian faith among participants further reinforces the relevance of Aliyu et al. (2025) and Anuforo et al. (2025) who emphasize that illnesses are often interpreted through spiritual or moral lenses in African settings, leading women to seek healing from religious or traditional providers.

The association between education and professional healthcare utilization in this study is consistent with findings by Demehin & Isiugo-Abanihe (2024) and Michael, Agbana & Naidoo (2024), who argue that education enhances health literacy and empowers women to reject harmful practices in favour of formal medical care. Similarly, income-related differences in health-seeking behaviour observed here echo the conclusions of Ezeaka, Akinwale and

Onwuegbuchulam (2025) and Akokuwebe & Idemudia (2022), who assert that lower socio-economic status often limits access to quality healthcare due to financial constraints. Our study also found that stigma and silence around menopause are significant barriers to care-seeking, particularly among women who consider menopause a private or misunderstood issue. This finding corroborates earlier studies by Zou et al. (2022) and Dias et al. (2021), who noted that cultural taboos around discussing women's health limit awareness and delay help-seeking. Respondents who kept menopause private or viewed it through a lens of myth and shame were less likely to utilize professional healthcare, consistent with Jahangirifar et al. (2023) and Hagos (2022), who reported similar experiences of silence and self-management.

Interestingly, the finding that women with strong social support (from spouses or peers) were more likely to seek professional help reflects studies such as Nguyen (2023) and Hayford (2023), which highlight how emotional and informational support reduces stigma and facilitates timely healthcare engagement. Conversely, lack of support from family or work environments was associated with delayed help-seeking, confirming the findings of Cronin et al. (2023) and MacLellan et al. (2023). However, our study differs from some earlier works in important ways. For instance, while Olowokere et al. (2021) suggest that cultural beliefs uniformly discourage formal healthcare seeking, our data showed a subset of respondents—particularly those with higher education and income—who consciously reject traditional remedies in favour of biomedical care. This divergence suggests that even within the same cultural milieu, socio-economic and professional exposure can moderate the effect of cultural norms.

Furthermore, although Falkingham et al. (2021) and Lukumay et al. (2023) report that menopause is universally viewed as a symbol of maturity and wisdom in African settings, our findings complicate this narrative. Many women in our study described menopause as a source of shame, social devaluation, or invisibility—echoing the findings of Blount (2021) and Ejidike (2022), who argued that perceptions of menopause are often ambivalent and context-dependent. Consistent with the Health Belief Model (HBM), respondents' perceived severity of symptoms, perceived benefits of care, and confidence in healthcare systems (self-efficacy) significantly influenced whether or not they sought professional help. This theoretical alignment strengthens the internal validity of the study and reinforces the relevance of HBM in understanding health behaviours during life transitions like perimenopause.

This study contributes to the growing body of evidence that health-seeking behaviour among perimenopausal women is shaped by an intricate interplay of socio-cultural, economic, and individual-level factors. It also affirms that interventions must address both structural (e.g., access, affordability) and cultural (e.g., stigma, beliefs) dimensions to improve health outcomes for midlife women in Nigeria and similar contexts.

## IMPLICATIONS FOR POLICY AND PRACTICE

The findings of this study have important implications for health policy and practice, particularly in the design and delivery of culturally appropriate, gender-sensitive healthcare services for perimenopausal women in Nigeria. The strong influence of cultural beliefs, stigma, and silence around menopause calls for targeted public health campaigns that normalize menopause as a natural phase of life. Policies should support educational outreach that demystifies menopause, counters misinformation, and promotes accurate knowledge through mass media, community outreach, and university-based wellness programmes. Healthcare providers must be trained to deliver culturally competent and empathetic care, particularly in dealing with sensitive health issues like menopause. Continuing medical education curricula should include modules on gendered and culturally embedded health behaviours, communication strategies, and stigma reduction.

Universities, as major employers of middle-aged women, should adopt workplace health policies that specifically address perimenopausal health, providing counselling, screening services, and referrals. The establishment of reproductive health desks in staff clinics could serve as a confidential and supportive point of care. The coexistence of support and stigma in the same

cultural setting implies that community-level interventions must be nuanced. Faith-based institutions, traditional leaders, and women's groups should be engaged as allies to facilitate open conversations and reduce harmful norms, while reinforcing positive cultural attitudes that support health-seeking. As low-income earners and junior staff were less likely to use professional healthcare services, there is a need for policies that increase access to affordable healthcare for underserved groups. Subsidized menopause-related services or inclusion in national health insurance packages can help bridge economic disparities.

## CONCLUSION

This study sheds light on the intricate interplay between stigma and support, culture and agency, that defines the health-seeking behaviour of perimenopausal women in Bayelsa Central, Nigeria. While education and employment appear to improve healthcare access, deeply rooted cultural norms, myths, and stigma continue to act as barriers, influencing women's decisions to seek or avoid professional care. The results reveal a dual reality: for some women, culture is a source of emotional and social support; for others, it is a source of silence, shame, and hesitation. The tendency to keep menopause private, the reliance on traditional or spiritual healing, and discomfort in clinical interactions are all manifestations of this cultural conditioning. Yet, there is also clear evidence of openness among women who embrace menopause and seek supportive, professional care, particularly when healthcare providers demonstrate cultural sensitivity.

This study is both timely and urgent. As Nigeria's aging female workforce expands, the lack of responsive health systems and community-based support for women undergoing menopause poses risks not only to individual wellbeing but also to public health outcomes and workforce productivity. If ignored, the consequences may include increased self-medication, worsening symptoms, avoidable complications, and erosion of trust in formal health systems. Addressing these challenges requires urgent, coordinated action that centres women's voices and experiences, especially those navigating perimenopause at the intersection of culture, employment, and healthcare. Creating inclusive, informed, and stigma-free healthcare environments will not only improve service uptake but also affirm the dignity and health rights of women in midlife.

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