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"We talk about it in private". A cross-sectional study of cultural attitudes and health-seeking practices among perimenopausal University staff in Bayelsa, Nigeria.

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Abstract
Background
Despite increasing recognition of women's midlife health challenges, the intersection of cultural norms and healthcare access during perimenopause remains underexplored in Nigeria's academic settings. This study explores how cultural attitudes shape health-seeking practices among perimenopausal university staff in Bayelsa, Nigeria.

Methods
Using a mixed-methods design, the study surveyed 313 academic and non-academic female staff aged 40–55 across two public universities. Quantitative data were analyzed using descriptive statistics and chi-square tests, while qualitative data from in-depth interviews were thematically examined.

Results
Findings reveal that cultural norms significantly influence women's willingness and ability to seek professional medical care during perimenopause. About 40.9% of respondents perceived cultural norms as moderately affecting their health-seeking behaviour, while 23.3% reported a significant influence. Chi-square analyses showed statistically significant associations between cultural perceptions, discussion openness, comfort with healthcare providers, and professional health-seeking patterns ($p < 0.001$). Qualitative narratives highlight both supportive and stigmatizing cultural contexts. Some women expressed comfort discussing menopause due to familial openness, while others cited stigma and fear of being perceived as old or weak as reasons for silence. Additionally, preferences for private healthcare stemmed from dissatisfaction with public hospital services, despite cost barriers.

Conclusions
The study emphasizes the need for culturally sensitive and gender-responsive healthcare services tailored to the needs of perimenopausal female professionals.

Recommendations
Health education programs should address stigma, negative cultural attitudes, poor health-seeking behaviour, and also foster open conversations about perimenopause, particularly within university institutions.

***Keywords**: perimenopause, cultural attitudes, health-seeking behaviour, university staff, Bayelsa, Nigeria, women's health, mixed-methods*
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Introduction
Perimenopause, the transitional period before menopause, marks a critical phase in a woman's reproductive life, often accompanied by physiological, psychological, and social changes (Cunningham et al., 2025; Maki & Jaff, 2022). These changes can significantly affect health and well-being, yet many women, particularly in sub-Saharan Africa, navigate this transition in silence due to prevailing socio-cultural norms (Agunbiade & Gilbert, 2020; Ejidike, 2022). In Nigeria, discussions around reproductive health are often shaped by traditional values and gendered expectations, which hinder timely and appropriate healthcare-seeking behaviour (Ifelunini et al., 2022; Anuforo et al., 2025).

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Despite growing awareness of women's midlife health challenges, a gap remains in scholarly attention to how cultural norms influence the health-seeking practices of educated, working women in academic environments (Adelekan-Kamara et al., 2023; O'Reilly et al., 2022). While university staff represent a relatively empowered demographic, their experiences of perimenopause are not insulated from the broader socio-cultural environment, especially in contexts where menopause is still shrouded in stigma and misunderstanding (Drew et al., 2022; Aljumah et al., 2023). In many Nigerian settings, menopause is viewed either as a biological inevitability best endured quietly or as a marker of declining womanhood, which fuels hesitancy in discussing symptoms and seeking professional care (Agunbiade & Gilbert, 2020; Ban & Zheng, 2022).

Studies have shown that health-seeking behavior is not solely influenced by individual knowledge or biomedical needs, but also shaped by cultural beliefs, social norms, and responsiveness of the health system (Nguyen et al., 2023; Aigbokhaode et al., 2023). Cultural silence surrounding menopause can result in delayed treatment, poor symptom management, and reduced quality of life (Han et al., 2022; Falkingham et al., 2021). Even within institutions of higher learning, where access to healthcare and information may be assumed, women's choices are still negotiated within cultural expectations (Edwards et al., 2021; Cronin et al., 2023).

Previous studies on perimenopause have predominantly focused on symptomatology, hormonal treatment, and the physiological effects of menopause, often within clinical or community settings and largely from a biomedical perspective (Cunningham et al., 2025; Maki & Jaff, 2022). Research in Nigeria and other parts of sub-Saharan Africa has also explored cultural taboos and the stigmatization of menopausal women, but mainly among rural or older, non-working populations (Agunbiade & Gilbert, 2020; Ejidike, 2022). What remains underexplored is how cultural norms influence the health-seeking behaviours of educated, working-class women, particularly within institutional settings like universities, where access to healthcare is assumed but not always utilized.

This study fills that gap by investigating the nuanced ways cultural attitudes shape the willingness of perimenopausal university staff in Bayelsa State, Nigeria, to seek professional healthcare. The title, 'We Talk About It in Private,' reflects the prevailing tension between private cultural discourses and public health needs, highlighting the importance of culturally sensitive, context-specific strategies for improving women's health outcomes during midlife. By integrating both qualitative and quantitative data, it offers a context-specific, culturally sensitive understanding of how even empowered populations are affected by socio-cultural constraints in managing perimenopausal health.

Theoretical Framework

This study is underpinned by the Health Belief Model (HBM) and complemented by insights from Symbolic Interactionism to explore the socio-cultural undercurrents that shape health-seeking practices among perimenopausal women in Bayelsa State. The Health Belief Model is a widely used social and psychological framework that explains individual decision-making related to health behaviours (Rosenstock, 1974; Green et al., 2020). It posits that individuals are more likely to engage in health-seeking actions if they:

- Perceive themselves to be *susceptible* to a health condition (e.g., complications of untreated menopausal symptoms),
- Perceive the condition as *serious*,
- Believe that a given health action would *reduce the severity or prevent the occurrence* of the condition (e.g., seeking professional care),
- Believe that the *benefits of taking action outweigh the barriers*, and
- They are *cued to action* by internal (e.g., symptoms) or external stimuli (e.g., advice from peers, cultural taboos).

Within the context of this study, the HBM helps to explain how cultural beliefs, knowledge levels, and personal experiences with perimenopause affect the perception of severity and benefits of formal healthcare engagement. For instance, when menopause is framed as a natural process requiring no intervention, women may not perceive a need for professional care, thus delaying or avoiding medical consultation. Additionally, fears of stigma, cultural silence, or prior negative experiences with health providers may act as barriers to action.

Symbolic Interactionism provides a sociological lens through which the meanings attached to menopause and health-seeking behaviours are constructed, negotiated, and internalized. Rooted in the work of Mead and Blumer, this theory posits that individuals act based on the meanings things have for them—meanings that are derived from social interaction and modified through interpretation (Blumer, 1986; Carter & Fuller, 2016). In the study context, menopause is not merely a biological event but a socially constructed experience shaped by interactions with family, colleagues, healthcare providers, and cultural norms. The reluctance to discuss menopause openly—reflected in the

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title *"We Talk About It in Private"*—demonstrates how meanings around aging, femininity, and reproductive worth are internalized and enacted. Women in professional settings, despite their education and access, may still adhere to or resist these symbolic norms in complex ways (Michael et al., 2024).

Together, these two frameworks allow for a comprehensive understanding of both individual-level motivations (HBM) and socially constructed meanings (Symbolic Interactionism). While HBM emphasizes perceived risk, benefits, and health actions, Symbolic Interactionism reveals the layered interpretations and cultural negotiations that shape those perceptions and decisions. By integrating these theories, the study captures not only *why* women may or may not seek care for perimenopausal symptoms, but also *how* cultural, institutional, and interpersonal interactions shape these decisions in subtle yet powerful ways. Hence, this study examines how cultural norms influence the health-seeking behaviours of perimenopausal university staff in Bayelsa state, Nigeria.

Methodology

Study Design

This study employed a mixed-methods cross-sectional design to investigate how cultural attitudes shape health-seeking practices among perimenopausal women working in university settings. The approach integrated both quantitative and qualitative methods to provide a comprehensive understanding of the phenomena under study. The cross-sectional nature of the design enabled the collection of data at a single point in time, capturing both the prevalence and context of health-seeking behaviours.

Study Setting

Niger Delta University (NDU) is a public university established in 2000 and situated on Wilberforce Island, part of the Nun River floodplain, about 30 km from Yenagoa in Bayelsa State. It has three campuses: the main Gloryland campus in Amassoma (home to the College of Health Sciences), a law faculty campus in Yenagoa, and a teaching hospital at Okolobiri. Surrounded by biodiverse tropical rainforest and mangrove swamps, NDU hosts over 20,000 students across more than a dozen faculties.

Bayelsa Medical University (BMU) is a state government–funded specialist medical institution established in August 2018. Located in Yenagoa, BMU includes faculties of Clinical, Basic Medical, Health, Pharmaceutical, and Science disciplines. The campus features modern laboratories, an e-library, an auditorium, and student hostels, with strong clinical affiliations to local hospitals.

Study Population

The study was conducted in Bayelsa Central Senatorial District, specifically at Niger Delta University (NDU) and Bayelsa Medical University (BMU). The study population comprised all female academic and non-academic staff aged 35–55 years, representing women at various stages of perimenopause. At the time of the study, a total of 962 eligible women were identified across both institutions.

Sample Size and Sampling Techniques

For the quantitative strand, the sample size was determined using the Taro Yamane formula (1967), resulting in a minimum of 282 respondents. An additional 10% was added to account for non-response, bringing the final sample to 313 women. A multi-stage sampling technique was used. First, the population was stratified by staff category (academic, senior non-academic, junior non-academic), followed by systematic random sampling within each stratum. For the qualitative component, 34 participants were purposively selected to capture variations in age, staff designation, and cultural background. Data saturation guided the final sample size (Michael, 2024).

Data Collection Methods

Quantitative data were collected using a structured and pretested questionnaire divided into eight sections, including socio-demographic characteristics, knowledge and awareness of perimenopause, socio-cultural beliefs, social support, and patterns of health-seeking behaviour. Qualitative data were gathered through in-depth interviews (IDIs) using a semi-structured guide that allowed for probing into personal and cultural meanings attached to menopause and healthcare decisions. Informed consent was sought from all participants, and confidentiality and anonymity were strictly maintained.

Data Analysis

Quantitative data were entered and analyzed using SPSS (Statistical Package for Social Sciences). Univariate analyses provided descriptive statistics; bivariate relationships were explored using Chi-square tests on the healthcare-seeking behaviour. Qualitative data were transcribed verbatim and analyzed thematically using ATLAS. TI software. Themes were generated through iterative reading and coding, guided by both deductive (based on research objectives) and inductive (emergent from data) processes.

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Validity and Reliability

Content validity of instruments was established through expert review, while the reliability of the quantitative tool was assessed using Cronbach's Alpha, with a threshold of 0.70 as acceptable. The qualitative guide was pretested, and credibility was ensured through member checking and triangulation of data sources.

Ethical Considerations

Ethical approval for this study was obtained from the College Ethic Committee of the College of Health Sciences, Niger Delta University (Ref No: 31-0912024/017) on 5th November 2024. All procedures adhered to the ethical principles of autonomy, confidentiality, beneficence, and non-maleficence, as outlined in the Helsinki Declaration on research involving human subjects. Participation in the study was entirely voluntary, and informed consent was obtained from all respondents before data collection. Participants were adequately informed about the study objectives, procedures, potential benefits, and their right to decline or withdraw at any stage without penalty. For both the questionnaire and in-depth interviews, no personally identifiable information was recorded, and respondents' anonymity was ensured through the use of numeric codes.

Bias

To minimize potential bias in the study, a validated, culturally adapted questionnaire was piloted among a similar demographic to ensure clarity and appropriateness, while data collectors received standardized training in neutral administration techniques and assured participants of confidentiality to reduce social desirability influences.

Eligibility Criteria

The study included female academic and non-academic staff aged 40–55 years employed at Niger Delta University (NDU) and Bayelsa Medical University (BMU) who self-identified as currently experiencing perimenopausal symptoms. Postmenopausal participants who had undergone surgical menopause (e.g., hysterectomy) or were on hormone replacement therapy were excluded to ensure the sample focused solely on naturally occurring perimenopausal experiences.

Results

Socio-Demographic Characteristics of Respondents

A total of 313 perimenopausal female staff participated in the quantitative component of the study, while 34 perimenopausal females participated in the qualitative interviews. The majority (63.3%) were aged 45–49 years, while 20.1% were below 44 years and 16.6% were 50 years or older. In terms of educational attainment, 38.0% had a Bachelor's/HND, 31.0% had post-secondary education, and 15.3% had postgraduate degrees. Most respondents were married (71.2%), and the vast majority (89.8%) were staff of Niger Delta University. Staff categorization revealed that 38.3% were senior non-academic staff, 37.7% were junior non-academic staff, and 24.0% were academic staff. A large proportion were Ijaw (81.8%), Christian (94.6%), and indigenes of Bayelsa State (81.8%). Monthly income was predominantly within the range of N100,000–N199,999 (64.2%).

Influence of Cultural Norms on Healthcare-Seeking Behaviour

Quantitative findings indicate that cultural norms significantly influence the health-seeking decisions of perimenopausal women in Bayelsa. As shown in Table 1, 40.9% of respondents reported that cultural beliefs moderately influenced their decisions to seek healthcare, while 23.3% noted a significant influence. In contrast, only 9.9% reported no influence at all. Chi-square analysis further confirmed a statistically significant association between levels of cultural influence and the likelihood of seeking professional care ($p < 0.001$). Respondents reporting stronger cultural influence were markedly less likely to utilize formal health services.

Table 1: Cultural Norms on Perception of Seeking Healthcare

Variable	Frequency	Percent
Not at all	31	9.90%
Slightly	81	25.90%
Moderately	128	40.90%
Significantly	73	23.30%
Total	313	100.00%

$X2 = 27.46; p < 0.001$

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The qualitative results offer deeper insight into these patterns. Some women internalized traditional beliefs that encourage the use of herbal or spiritual remedies and delay seeking professional help:

"In my community, women often believe that menopause should be managed with herbs, and they only visit hospitals when symptoms become unbearable." (Respondent 018, BMU, Age 49, Non-Academic Staff).

On the other hand, a few participants, particularly those with greater access to education and formal healthcare, emphasized rational and science-based decisions over cultural dictates:

"Culture does not influence my health decisions at all. I rely on medical advice, not traditional beliefs." (Respondent 003, NDU, Age 49, Academic Staff)

These perspectives suggest that while cultural norms play a dominant role in shaping health-seeking behaviour for many, there is variation based on individual belief systems, access to resources, and social support structures.

Perceptions and Privacy Surrounding Menopause

Cultural beliefs about menopause deeply influenced whether women chose to discuss it or seek healthcare. Table 2 illustrates the relationship between types of cultural perception and health-seeking behaviour. Among those who embraced menopause as a natural life stage, 81.3% sought professional care, compared to only 37.5% of those who viewed it as surrounded by myths and misconceptions. Women who considered menopause a private matter also reported low rates of professional healthcare-seeking (57.7%). Chi-square analysis revealed a statistically significant relationship between cultural perception and professional healthcare use ($p < 0.001$).

Table 2: Cultural Perceptions of Menopause and Health-Seeking Behaviour

Perception Type	Health-seeking behaviour				
	Non-Professional (n, %)	Professional (n, %)	Total (n, %)	X2	P-value
Embraced as a natural life stage	18 (18.8%)	78 (81.3%)	96 (100%)	34.896	<0.001
Discussed openly but with some stigma	14 (23.7%)	45 (76.3%)	59 (100%)		
Considered a private matter	30 (42.3%)	41 (57.7%)	71 (100%)		
Surrounded by myths and misconceptions	35 (62.5%)	21 (37.5%)	56 (100%)		
Other	11 (35.5%)	20 (64.5%)	31 (100%)		

The qualitative findings support these patterns. In some families and communities, menopause is discussed openly and supportively, fostering preparedness and encouraging professional care:

"In my family, we talk about menopause openly. My aunts always shared their experiences, so I knew what to expect." (Respondent 011, NDU, Age 47, Academic Staff)

In contrast, for many others, menopause is treated as a personal or even shameful matter, often hidden from public discourse:

"I don't talk about it at all. It is a personal journey, and some people see it as a sign of aging and weakness." (Respondent 007, BMU, Age 47, Academic Staff)

These divergent views reveal how sociocultural constructions of menopause, as either a biological transition or a stigmatized condition, shape privacy norms, which in turn influence access to medical support.

Comfort with Discussing Menopause and Interactions with Healthcare Providers

Respondents' comfort levels when discussing menopause with healthcare providers were found to be significantly associated with their likelihood of seeking professional care. As shown in Table 3, 80.8% of those who felt very comfortable sought professional care, compared to only 36.2% of those who were very uncomfortable. Chi-square analysis confirmed this association as statistically significant ($p < 0.001$).

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Table 3: Comfort Discussing Menopause with Healthcare Providers and Health-Seeking Behaviour

Comfort Level	Health-seeking behaviour				
	Non-Professional (n, %)	Professional (n, %)	Total (n, %)	X2	P-value
Very comfortable	19 (19.2%)	80 (80.8%)	99 (100%)	33.000	<0.001
Moderately comfortable	29 (36.3%)	51 (63.7%)	80 (100%)		
Somewhat uncomfortable	23 (30.3%)	53 (69.7%)	76 (100%)		
Very uncomfortable	37 (63.8%)	21 (36.2%)	58 (100%)		

The qualitative narratives offer insight into these patterns. Women who reported high comfort levels cited empathetic communication and trust in their healthcare providers:
"I feel very comfortable talking to my doctor because she understands what I am going through and provides helpful advice." (Respondent 008, NDU, Age 49, Academic Staff)
Others, though willing to engage, found their experiences with health providers lacking in attentiveness or understanding:
"I can discuss my symptoms, but I don't always feel fully understood. Some doctors don't take menopause seriously." (Respondent 019, BMU, Age 52, Non-Academic Staff)
Finally, discomfort and mistrust were barriers for some, leading to self-management and avoidance of formal care:
"I feel uncomfortable talking about it because some doctors make it seem like it's not a big deal. I would rather manage it on my own." (Respondent 033, NDU, Age 47, Academic Staff)
These findings emphasize the role of provider-patient dynamics in influencing healthcare decisions and highlight the need for more gender-sensitive and culturally informed communication strategies in clinical settings.

Healthcare Preferences and Accessibility

Women's choices between public and private healthcare facilities during perimenopause reflected a tension between cost, accessibility, and quality of service. Although no quantitative questions explicitly captured facility preference, qualitative interviews revealed recurring themes regarding women's healthcare-seeking decisions.
Participants who preferred private hospitals cited shorter wait times, better provider attitudes, and a more organized environment despite the higher costs. One respondent stated:
"I prefer going to private hospitals because they attend to patients faster than government hospitals." (Respondent 013, NDU, Age 47, Academic Staff)
In contrast, public healthcare facilities were more affordable and thus accessible to women with limited incomes. However, complaints about outdated equipment, long queues, and drug shortages were common:
"Government hospitals are cheaper, but they don't always have the drugs or equipment needed." (Respondent 008, BMU, Age 46, Academic Staff)
These findings demonstrate the structural constraints faced by perimenopausal women, especially those from lower socioeconomic backgrounds, who must weigh the quality of care against financial cost and systemic inefficiencies in the public sector.

Cultural Stigma and Healthcare

Cultural stigma surrounding menopause emerged as a key barrier to professional healthcare engagement. As shown in Table 4, among respondents who reported no experience of stigma, 80.6% accessed professional care, compared to 48.6% of those who encountered stigma—a difference found to be statistically significant ($p < 0.001$). Stigmatizing beliefs were often linked to aging, weakness, or diminished womanhood, deterring some women from discussing symptoms or seeking help.

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Table 4: Cultural Stigma and Health-Seeking Behaviour

Encountered Cultural Stigma	Health-seeking behaviour				
	Non-Professional (n, %)	Professional (n, %)	Total (n, %)	X2	P-value
No	32 (19.4%)	133 (80.6%)	165 (100%)	35.258	
Yes	76 (51.4%)	72 (48.6%)	148 (100%)		

However, stigma was not universal. In more open and supportive contexts, menopause was seen as a normal biological phase:

"I have never faced any stigma because of menopause. In my workplace and family, it is seen as a natural stage of life." (Respondent 012, BMU, Age 50, Academic Staff)

Expectations from Healthcare Providers

Healthcare provider expectations also influenced behaviour. As shown in Table 5, women who expected culturally sensitive care or actively sought information independently were more likely to engage professional services (73.5% and 75.0%, respectively). Conversely, those who preferred not to discuss cultural aspects of menopause had lower rates of professional health-seeking (47.5%).

Table 5: Expectations from Healthcare Providers and Health-Seeking Behaviour

Expectation Type	Health-seeking behaviour				
	Non-Professional (n, %)	Professional (n, %)	Total (n, %)	X2	P-value
35 (26.5%)	97 (73.5%)	132 (100%)	21.359	<0.001	
20 (25.0%)	60 (75.0%)	80 (100%)			
53 (52.5%)	48 (47.5%)	(100%)			

Qualitative data illuminated these dynamics. Some women desired empathetic care that respected cultural norms:
"I expect my doctor to understand that in our culture, menopause is not openly discussed. It would help if they approach it sensitively and with respect for our beliefs." (Respondent 012, BMU, Age 50, Academic Staff)
Others preferred to take the initiative in learning about menopause due to perceived gaps in medical guidance:
"I prefer to read about menopause and find solutions myself rather than relying on doctors who may not fully understand my concerns." (Respondent 027, NDU, Age 48, Non-Academic Staff)
Some deliberately avoided discussing cultural dimensions with providers, reflecting discomfort or mistrust:
"I only want medical advice. I don't feel comfortable discussing cultural aspects with my doctor because they may not relate to my experiences." (Respondent 035, NDU, Age 46, Academic Staff)
Together, these findings highlight the importance of culturally competent care and the need for improved patient-provider communication that validates women's lived experiences.

Discussion

This study aimed to examine how cultural attitudes influence the health-seeking behaviour of perimenopausal university staff in Bayelsa, Nigeria. The findings reveal that despite being educated and professionally employed, many of the respondents were significantly influenced by cultural beliefs and social norms that shaped their understanding and management of perimenopause. Notably, the study found that 64.2% of participants reported that cultural beliefs either moderately (40.9%) or significantly (23.3%) affected their decision to seek healthcare during the perimenopausal phase. This confirms the study's primary objective and underscores the persistent power of socio-cultural context in shaping health behaviours, even within academic institutions.
A key interpretation of this finding is that cultural norms, particularly those that frame menopause as a shameful or private matter, directly deter formal healthcare utilization. Women who perceived menopause as a natural life stage were more likely to seek professional help, while those who viewed it through the lens of stigma or myths avoided

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discussions or treatment. This aligns with earlier studies by Agunbiade & Gilbert (2020), Ban & Zheng (2022), and Zou et al. (2022), which found that stigma, myths, and gendered expectations limit open dialogue and delay care in both African and Asian societies.

Comfort in discussing menopause with healthcare providers emerged as another significant factor influencing health-seeking. Women who felt 'very comfortable' discussing their symptoms with providers were more likely to seek professional care (80.8%), compared to those who felt 'very uncomfortable' (36.2%). These findings echo those of Adeoye et al. (2024), Richardson et al. (2023), and Blount (2021), who observed that empathetic communication and provider sensitivity encourage patient engagement, while dismissiveness or lack of understanding serve as a deterrent.

Additionally, healthcare preferences illustrated structural and economic dimensions to care-seeking. Although private facilities were favoured for their efficiency and better treatment environments, many women could not afford them and turned to public hospitals despite complaints about poor services. These findings are consistent with previous research by Eze et al. (2025) and Nguyen et al. (2023), which found that cost and perceived quality are key determinants of healthcare utilization among middle-aged women in low- and middle-income settings.

Cultural stigma further constrained professional health-seeking behaviour. Women who had experienced stigma were significantly less likely to utilize formal health services. This supports evidence from Han et al. (2022) and Ejidike (2022), who documented how cultural shame associated with menopause fosters silence and self-management. On the other hand, a minority of participants reported supportive family environments that encouraged proactive healthcare use—an observation that aligns with Drew et al. (2022), who advocated for family-based health literacy interventions to reduce stigma.

Importantly, this study contributes original insights by focusing on educated, employed women in university settings, a group often assumed to be less affected by cultural limitations. However, our findings contradict this assumption and reinforce arguments by Agunbiade & Gilbert (2023) and Demehin & Isiugo-Abanihe (2024) that education and institutional affiliation alone do not eliminate socio-cultural constraints around menopause and aging. Unlike Dias et al. (2021), who argued that workplace resources increase access, this study reveals that silence and stigma within professional environments can still inhibit health-seeking.

The findings confirm that cultural perceptions, communication with healthcare providers, structural healthcare limitations, and socio-economic factors are intricately linked in shaping perimenopausal women's health-seeking behaviours. It calls for gender-responsive, culturally competent, and accessible health services that not only provide treatment but also create safe spaces for dialogue, education, and empowerment for midlife women.

Study Strengths

The strengths of this study include the integration of quantitative survey data with qualitative narratives that provided a comprehensive understanding of how cultural attitudes influence perimenopausal women's health-seeking behaviour. This methodological triangulation enhanced the validity and depth of the findings. By focusing on university staff in Bayelsa State, Nigeria, the study highlights a relatively underexplored group, formally educated women who may still face socio-cultural barriers in health access. This helps to illuminate that educational attainment alone does not eliminate cultural influence on health practices.

Implications for Policy and Practice

The findings have both policy and practice implications. Healthcare providers must be trained in culturally competent communication, especially regarding sensitive life stages like menopause. As the study reveals, provider empathy, attentiveness, and cultural awareness directly influence whether women seek professional care. Integrating modules on menopause and gender-sensitive communication into medical and nursing education, guided by frameworks like those suggested by Blount (2021) and Cronin et al. (2023), can help address stigma and improve care experiences. Tertiary institutions, including universities, should design and implement workplace wellness programs that include menopause education and psychosocial support. Given that a majority of the study's participants were university staff, institutions are well-positioned to model best practices by creating safe spaces for discussion, offering counselling services, and promoting awareness through seminars and human resources policies. This aligns with global calls for workplace-focused interventions (Adelekan-Kamara et al., 2023; Verdonk et al., 2022).

While affordability draws women to public healthcare facilities, the perceived inefficiency, long wait times, and lack of drug availability often discourage continued use. Policymakers at the federal and state levels must address these structural issues to ensure that public health services

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are both accessible and trusted. The silence and stigma around menopause, even among educated populations, reveal a gap in culturally relevant health education. Ministries of Health and NGOs should incorporate menopause awareness into broader reproductive health campaigns, particularly using radio, community meetings, and digital platforms to reach diverse audiences. Menopause-related symptoms and counselling should be routinely addressed at primary care levels, alongside other reproductive and non-communicable health screenings. Standardizing menopause support within Nigeria's national primary healthcare guidelines, similar to maternal and child health services, would enhance early detection and management of symptoms and reduce long-term complications such as depression, osteoporosis, or cardiovascular risk. Also, this study calls for a reframing of menopause as a gender equity issue in healthcare. Drawing on the principles of *negofeminism* (Udenigwe et al., 2023) and gendered norms theory (Michael et al., 2025), policies must empower women to challenge silence, seek support, and claim health services that respect their dignity, autonomy, and lived experiences.

Conclusion

This study provides important insights into how cultural attitudes and social norms influence health-seeking behaviour among perimenopausal women working in university settings in Bayelsa, Nigeria. The findings reveal that while a portion of women actively seek professional care, many others experience discomfort, silence, or stigma that discourages open discussion and timely healthcare engagement. The role of cultural perceptions, ranging from viewing menopause as a natural life stage to associating it with aging and decline, emerged as a powerful determinant of whether and how women seek help. The mixed-methods approach employed in this study demonstrates the complexity of perimenopausal experiences, illustrating that quantitative trends are deeply intertwined with socio-cultural narratives.

While education and employment in academic institutions may offer some protective effects, structural weaknesses in healthcare systems, combined with cultural taboos, continue to limit women's access to appropriate and respectful care. Addressing these challenges requires a multi-pronged strategy, strengthening culturally competent health services, reducing stigma through education and workplace awareness, and ensuring that menopause is treated as a critical component of women's health, deserving of policy attention and public health investment. Ultimately, breaking the silence around menopause can empower women to seek care with dignity and improve their health outcomes during this significant life transition.

Study Limitations

The limitations include that the study sample was restricted to university staff in two public institutions within one Nigerian state, which may not reflect the experiences of women in private institutions, other sectors, or rural communities. Both the quantitative and qualitative findings rely on self-reported data, which are subject to recall bias and social desirability bias, especially on culturally sensitive topics like menopause. The study focused on perceptions and health-seeking behaviour without including clinical evaluations or medical records that could have validated or deepened the understanding of participants' health status and treatment histories. The generalizability of these study findings is limited to similar institutional and sociocultural settings, particularly among educated, employed women in urban areas of the Niger Delta region. Caution should therefore be exercised in applying the results to rural populations or women outside the university system, where cultural norms and access to health services may differ.

Recommendations

Health education programs should address stigma, negative cultural attitudes, poor health-seeking behaviour, and also foster open conversations about perimenopause, particularly within university institutions.

List Of Abbreviations:

BMU: Bayelsa Medical University
FCT: Federal Capital Territory
HBM: Health Belief Model
HND: Higher National Diploma
IDIs: In-Depth Interviews
NDU: Niger Delta University
NGO: Non-Governmental Organization
SDGs: Sustainable Development Goals
SPSS: Statistical Package for the Social Sciences
SSA: Sub-Saharan Africa
UK: United Kingdom
WHO: World Health Organization

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Authors' Contributions

USA and EAS conceived the proposal; USA performed data analysis, USA and GATS participated in data

interpretation; USA, GATS, and EAS drafted the original manuscript; USA, GATS, and EAS participated in manuscript reviewing and editing. All the authors read and agreed on the final manuscript.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data used to produce this study are available from the corresponding author upon reasonable request.

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