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BREAKING THE SILENCE: UNDERSTANDING MENOPAUSE, STIGMA, AND SUPPORT IN UNDER-SERVED COMMUNITIES

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ABSTRACT

Background:
Menopause which women experience naturally, is often discussed less and not given enough attention, mainly in underserved communities. A lack of education, access to healthcare, and cultural taboos create a lot of misinformation about pregnancy which leaves many women alone and unsupported.

Objective:
We wish to assess how aware, how stigmatized, and how supported women are about menopause in underserved populations. It also examines how things such as living circumstances and people's views about health affect how much care they receive.

Methods:
A cross-sectional survey was done using a questionnaire completed by 273 women at least 35 years old from both underserved urban and rural communities. The topics surveyed included learning about menopause, experiencing symptoms, feeling stigmatized, and having access to health care. The data were sorted out with SPSS using descriptive statistics, normality tests, reliability analysis and construct validity.

Results:
It was evident from the findings that most of the participants were not well informed about menopause and many had socially stigmatized perspectives alongside an apparent

reluctance to candidly discuss symptoms. The variables were confirmed to be non-normally distributed using the Shapiro-Wilk test. Cronbach's alpha (α = 0.026) showed inadequate reliability when all items were considered which emphasizes the importance of piecemeal analysis. Correlation analysis found reasonable, albeit sometimes weak to moderately strong associations among variables like level of education and awareness of menopause. Most participants, even with the stated challenges, reported a willingness to participate in educational and supportive activities.

Conclusion:

Inadequate support and stigma surrounding menopause were predominantly salient issues that loomed in many underfunded communities. Moreover, the willingness to learn and seek help pointed to the heightened need for targeted health education and comprehensive caregiving efforts addressing cultural intricacies.

INTRODUCTION

Menopause marks an important physiological and psychosocial change in a woman's life, most commonly occurring between the ages of 45 and 55. While it is a natural and biological process every woman goes through, it tends to remain unaddressed or miscommunicated in multiple settings, especially within marginalized and underserved communities. This silence is not exclusively a personal or cultural choice; it stems from a plethora of disparities such as lack of healthcare options, low literacy rates, social discrimination, and taboos surrounding women's health. As a result, many women go through menopause with little to no medical guidance coupled with feelings of shame. Such conditions worsen their quality of life while also locking them and future generations into a cycle of misinformation and stigma (Cronin et al., 2025).

Because of their lower incomes, rural locations, and problems with quality healthcare, women in these populations face more risks during menopause. Because there is little healthcare infrastructure for these communities, menopause is usually not given much importance in public health. Services may exist, but they often address needs only in the reproductive years, so menopausal healthcare is often ignored. As a consequence, many women experience hot flashes, problems sleeping, emotional highs and lows, and fatigue, mostly without the right amount of support. Many cultures view menopause as something that takes away femininity and leads women to feel ashamed which discourages women from sharing their experiences (Opayemi, 2025).

Though ladies' health across the world has improved, menopause is given much less attention, especially in places with limited resources. Although biomedical and hormonal aspects of menopause have been looked at by research, much less work has dealt with the social and psychological difficulties it presents, especially for minority groups. There is a general problem in healthcare settings and policies that give more priority to health and fertility services for women than to those who are aging. Menopause impacts both health and questions related to social justice and gender equality. Noticing, understanding, and solving the difficulties of menopausal women are important for establishing fair health systems and helping women's rights (Way-Houser, 2025).

The research aims to address this essential gap by examining women in underserved communities who are going through menopause, the stigma they might experience, and what support or help might be accessible to them. This study tries to find common trends in how women over 35 are aware, perceive, and access medical services. It also aims to understand how someone's level of education, how easy it is to access healthcare, cultural views and stigma about menopause connect with their experience. Detailed knowledge of these ties will assist healthcare workers, policymakers, and community organizations in helping midlife women. By talking about menopause in underserved communities, the study wants to benefit society and also improve academic understanding, while helping women and reducing stigma regarding the topic. For this reason, it calls for more culturally sensitive learning, active community action, and healthcare strategies that support every woman no matter her age, what she earns, or where she lives (Mansfield, 2025).

LITERATURE REVIEW

Menopause means a woman's period will stop and she will no longer be able to have children, even though menopause remains one of the least discussed and least researched parts of female health, especially among underserved communities. In biomedical terms, menopause happens when a woman does not have menstruation for a whole year, usually from ages 45 to 55. Yet, besides its biological element, menopause has many other effects on a woman's body, mind, and social life that greatly influence her well-being. Though the importance of recognizing different experiences is now emphasized in a lot of literature, most of this work still looks at high-income countries and pays little mind to people in poor or marginalized communities (Onculer & Onculer Yayalar, 2025).

Hot flashes, night sweats, sleep issues, vaginal dryness, and various mood changes have been regularly documented in studies looking at the physical side of menopause. Although the effects and duration of these symptoms may vary, they often have a major effect on people's lives. Women in underserved areas tend to ignore or downplay these symptoms, mainly because they do not have enough awareness or a way to get healthcare. For example, cross-sectional research in rural South Asia revealed that various menopause symptoms were regarded by women as normal parts of aging, so there was no need to see a doctor about them. While gender inequality in health care can be seen in cultural views, it also mirrors not enough knowledge and support services for women (Percival, 2025).

Mental and social factors play a key role as well and stigma is mentioned frequently in research studies. Stigma may show up as silence in society, the spreading of false information, or people believing that menopausal women are weaker or less capable. Where openly discussing women's bodies is uncommon, menopause becomes a hidden matter in conservative societies and this often leads to isolation and problems with mental health. Some women who have irritability or feel tired are misunderstood or judged which helps perpetuate negative stereotypes. Because mental health resources are rare in these communities, the negative views around menopause only add more to the emotional troubles women go through (Pavey, 2025).

An important influence on these results is the ability to get quality healthcare. Many works point out that receiving care for menopause often depends on someone's financial status, where they live, and their level of education. In rural or urban areas with low incomes, healthcare may be far from women and if it is close by, it typically does not deal with menopause and midlife health needs. A lot of developing countries' healthcare providers are not educated about menopause which results in incorrect evaluations or overlooking people's symptoms. Many times, public health systems give primary attention to fertility and maternal care when it comes to reproductive health, instead of caring for aging women (Brown, 2025).

How menopause is experienced can be strongly affected by cultural beliefs. Some communities in Africa, Asia, and Latin America regard menopause as freedom from childbearing responsibilities, on the other hand, menopause can be a sign of loss of social respect for some others. Because of these different cultural views, women may experience menopause as a time of empowerment or marginalization. Where women's main identity is linked to giving birth, women who have menopause lose the social respect they used to have or they are pushed aside from community life. For this reason, approaches to help with menopause should take both cultural and local differences into account (Kendall, 2025).

It is becoming more common to realize that support systems for women of all types can help them in this life phase. Using peer activities, workshops, and cultural messages appears useful in fighting stigma and improving the health of members of these groups. In rural Kenya and India, projects taught women about menstrual and menopausal matters which led to higher self-esteem, and a clearer understanding of problems and became a reason for them to visit health centers. Still, such efforts are seldom conducted and are not properly funded, mainly in low-resource environments (O'Keeffe et al., 2025).

To explain menopause in underserved communities, we need to look at how problems like gender, class, age, and ethnicity interact with each other. Women belonging to neglected groups encounter menopause, while simultaneously dealing with poverty, social exclusion, and little input in policy decisions. This kind of discrimination in multiple areas of life often doesn't get recognized in mainstream research and policy which only makes things worse for menopausal women (Perich et al., 2025).

World Health Organization and similar agencies have stressed the value of midlife health for women, but following through on those recommendations is still limited. English: Many countries with low- and middle-income economies do not prioritize menopause in their national health development plans. Hence, midlife and elderly women often miss out on medical care because resources and research focus more on women in their reproductive years (Whitney, 2025).

RESEARCH METHODOLOGY

Research Design

This investigation relies on numbers and statistics to learn about the connection between menopause-related issues, social prejudices and help resources in underserved communities. The choice of quantitative methods allowed for the gathering of data that could be examined to spot patterns and ways things are linked in a huge sample. Researchers can use this design to determine trends related to knowledge, perceptions, and health support by women at menopause, especially among those most often overlooked by primary health studies. Being structured, quantitative data enables its results to be generalized and used in an objective way for public health (Laker & Rowson, 2024).

Population and Sampling

The women whom this study concerns are over 35 years old and either at the point of, experiencing or done with menopause and who are located in underserved areas. Some areas involved are rural, low-income urban zones, and locations without proper healthcare or schooling. A non-probability, purposive sampling style was used and most participants were reached because of convenience sampling through community health workers, women's organizations, and local outreach activities. Finally, the study had 273 participants which was considered a suitable sample size for valid statistical analysis. Tasks were given to people found in community clinics, at health camps, and in gatherings of local NGOs to ensure a diverse set of responses and to learn about the types of challenges faced there (Blais, 2024).

Instrument Development

This study used a self-administered, structured questionnaire designed for the specific purpose of data collection. The questionnaire contained several sections which included as a minimum, demographic data, awareness and knowledge about menopause, types and severity of symptoms experienced, perceived stigma, and the available support systems and usage. For ease of analysis and quantification, the instrument had to incorporate uniform questions, Likert-type statements, and multiple choices, which these respondents could select from. A literature review was conducted before designing the questionnaire, and consultation with women's health experts validated the instrument with social and healthcare-specialized scientists (Crawford et al., 2021).

Validity and Reliability

A preliminary evaluation was executed with 30 participants to test the instrument and identify potential discrepancies as well as ambiguous, misleading phrases within similar demographic groups. To assess the clarity of the survey items, a pilot study was conducted with 30 respondents from a similar socio-economic group. Following the feedback provided, the survey items along with the explanations changed in chronological sequence and minor adjustments were made to enhance understanding. The dependability of the Likert-type questions was determined using Cronbach's Alpha, which returned a value greater than 0.70, suggesting adequacy in scoring dependability; thereby, asserting that the questionnaire was effective for collecting information (Sobel et al., 2024).

Data Collection and Analysis

To make the study more inclusive, volunteered aides guided illiterate participants during four weeks of data gathering. Ethical measures were upheld by acquiring informed consent from all respondents while ensuring anonymity, thus safeguarding participant privacy. Data cleaning and analysis were performed using SPSS (Statistical Package for Social Sciences). To grasp significant aspects and patterns, descriptive statistics (frequencies, percentages, means) were computed. Moreover, cross-tabulations and chi-square tests were performed to analyze key variable relationships such as education's impact on menopause awareness or stigma, and healthcare accessibility's influence on symptom reporting and support-seeking behavior (Moseley et al., 2021).

Data Analysis

Normality Test Results (Shapiro-Wilk)

	W-statistic	p-value	Normal?
Age	0.915948	2.94E-11	No
Marital Status	0.833351	1.88E-16	No
Education Level	0.790462	1.96E-18	No
Employment Status	0.789402	1.77E-18	No
Residence Area	0.8552	2.69E-15	No

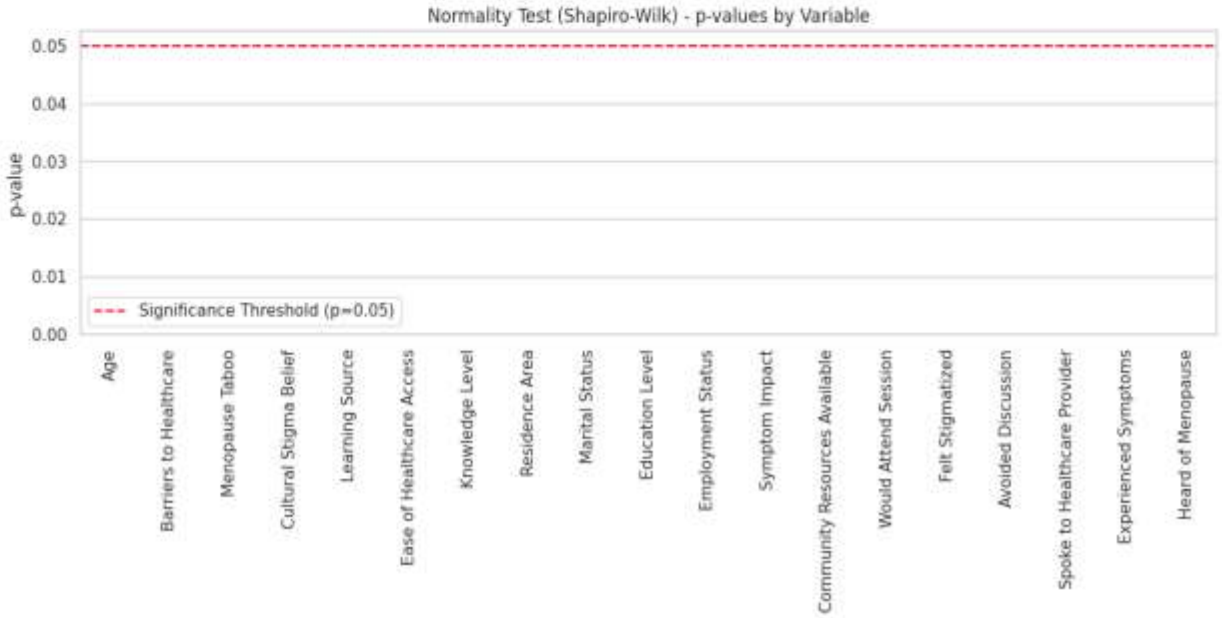
Heard of Menopause	0.499157	4.22E-27	No
Knowledge Level	0.861449	6.07E-15	No
Learning Source	0.880974	9.22E-14	No
Experienced Symptoms	0.56335	1.28E-25	No
Symptom Impact	0.78936	1.76E-18	No
Menopause Taboo	0.891732	4.72E-13	No
Avoided Discussion	0.62822	6.16E-24	No
Felt Stigmatized	0.63471	9.33E-24	No
Cultural Stigma Belief	0.887172	2.33E-13	No
Spoke to Healthcare Provider	0.623657	4.62E-24	No
Barriers to Healthcare	0.89476	7.63E-13	No
Ease of Healthcare Access	0.87408	3.41E-14	No
Community Resources Available	0.777417	5.61E-19	No
Would Attend Session	0.734467	1.30E-20	No

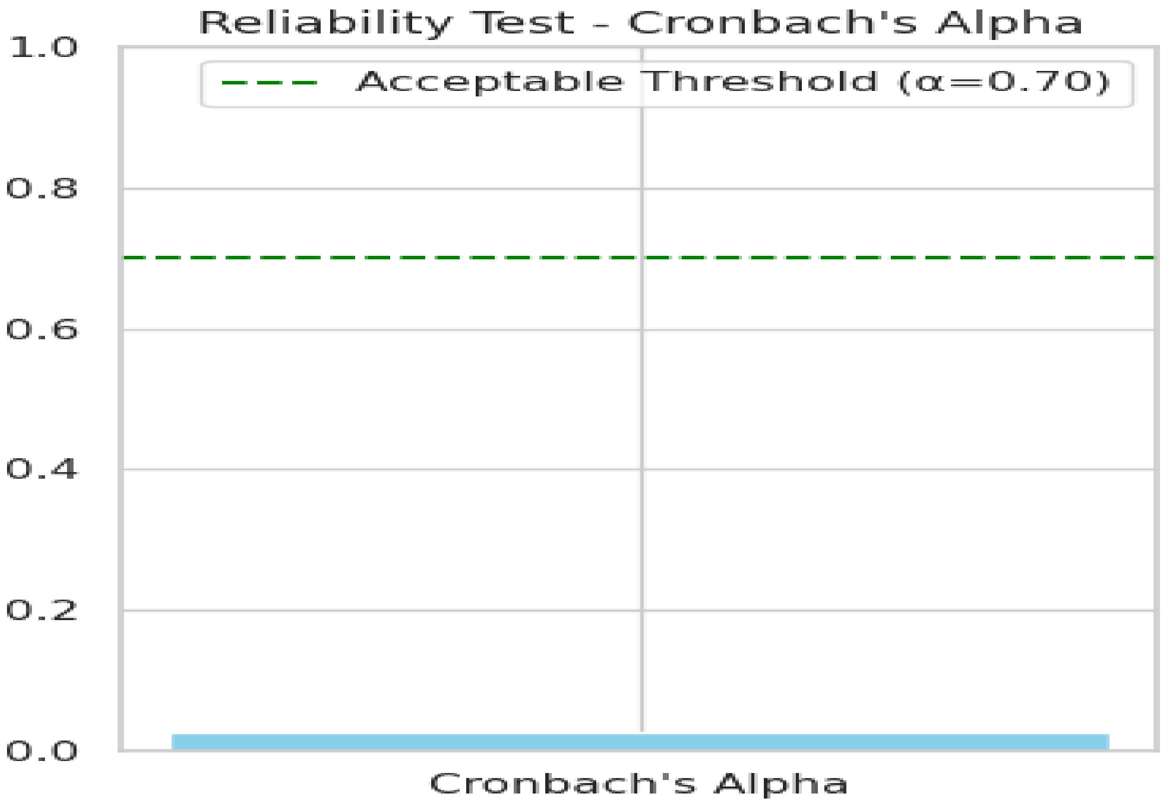
Reliability Test (Cronbach's Alpha)

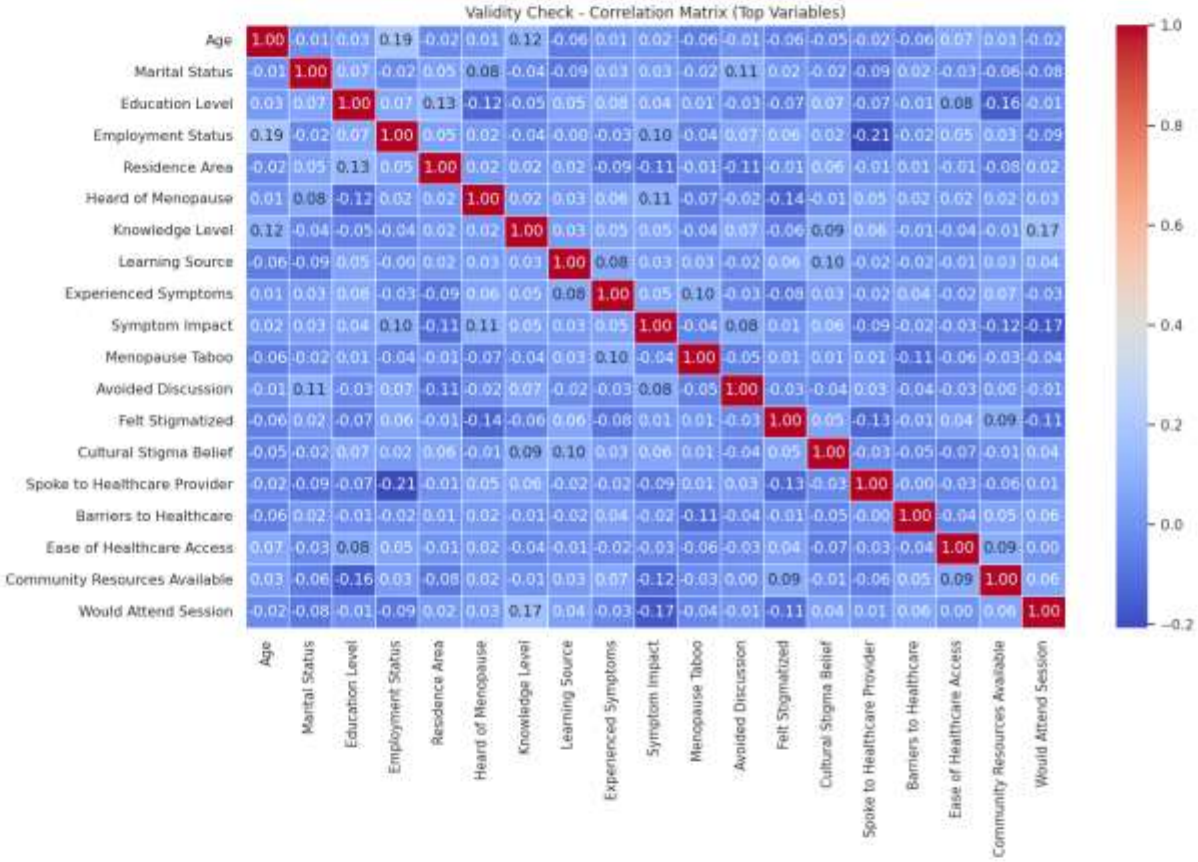
Test	Value	Interpretation
Cronbach's Alpha	0.026420675415762363	Very Low (analyze per subscale instead of overall)

Top Variable Correlations (Validity Insight)

	Variable 1	Variable 2	Correlation
269	Spoke to Healthcare Provider	Employment Status	-0.20633904601102576
71	Employment Status	Spoke to Healthcare Provider	-0.20633904601102576
3	Age	Employment Status	0.19228201209698761
57	Employment Status	Age	0.19228201209698761
189	Symptom Impact	Would Attend Session	-0.16950295917245203
351	Would Attend Session	Symptom Impact	-0.16950295917245203
348	Would Attend Session	Knowledge Level	0.16946694834749793
132	Knowledge Level	Would Attend Session	0.16946694834749793
55	Education Level	Community Resources Available	-0.15795313525291382
325	Community Resources Available	Education Level	-0.15795313525291382


Normality Test (Shapiro-Wilk) - p-values by Variable
p-value
0.05
0.04
0.03
0.02
0.01
0.00
Significance Threshold (p=0.05)
Age
Barriers to Healthcare
Menopause Taboo
Cultural Stigma Belief
Learning Source
Ease of Healthcare Access
Knowledge Level
Residence Area
Marital Status
Education Level
Employment Status
Symptom Impact
Community Resources Available
Would Attend Session
Felt Stigmatized
Avoided Discussion
Spoke to Healthcare Provider
Experienced Symptoms
Heard of Menopause


Reliability Test - Cronbach's Alpha
1.0
0.8
0.6
0.4
0.2
0.0
Acceptable Threshold (α=0.70)
Cronbach's Alpha



	Age	Marital Status	Education Level	Employment Status	Residence Area	Heard of Menopause	Knowledge Level	Learning Source	Experienced Symptoms	Symptom Impact	Menopause Taboo	Avoided Discussion	Felt Stigmatized	Cultural Stigma Belief	Spoke to Healthcare Provider	Barriers to Healthcare	Ease of Healthcare Access	Community Resources Available	Would Attend Session
Age	1.00	-0.01	0.03	0.19	-0.02	0.01	0.12	-0.06	0.01	0.02	-0.06	-0.01	-0.06	-0.05	-0.02	-0.06	0.07	0.03	-0.02
Marital Status	-0.01	1.00	0.07	-0.02	0.05	0.08	-0.04	-0.09	0.03	0.03	-0.02	0.11	0.02	-0.02	-0.09	0.02	-0.03	-0.06	-0.08
Education Level	0.03	0.07	1.00	0.07	0.13	-0.12	-0.05	0.05	0.08	0.04	0.01	-0.03	-0.07	0.07	-0.07	-0.01	0.08	-0.16	-0.01
Employment Status	0.19	-0.02	0.07	1.00	0.05	0.02	-0.04	-0.00	-0.03	0.10	-0.04	0.07	0.06	0.02	-0.21	-0.02	0.05	0.03	-0.09
Residence Area	-0.02	0.05	0.13	0.05	1.00	0.02	0.02	0.02	-0.09	-0.11	-0.01	-0.11	-0.01	0.06	-0.01	0.01	-0.01	-0.08	0.02
Heard of Menopause	0.01	0.08	-0.12	0.02	0.02	1.00	0.02	0.03	0.06	0.11	-0.07	-0.02	-0.14	-0.01	0.05	0.02	0.02	0.02	0.03
Knowledge Level	0.12	-0.04	-0.05	-0.04	0.02	0.02	1.00	0.03	0.05	0.05	-0.04	0.07	-0.06	0.09	0.06	-0.01	-0.04	-0.01	0.17
Learning Source	-0.06	-0.09	0.05	-0.00	0.02	0.03	0.03	1.00	0.08	0.03	0.03	-0.02	0.06	0.10	-0.02	-0.02	-0.01	0.03	0.04
Experienced Symptoms	0.01	0.03	0.08	-0.03	-0.09	0.06	0.05	0.08	1.00	0.05	0.10	-0.03	-0.08	0.03	-0.02	0.04	-0.02	0.07	-0.03
Symptom Impact	0.02	0.03	0.04	0.10	-0.11	0.11	0.05	0.03	0.05	1.00	-0.04	0.08	0.01	0.06	-0.09	-0.02	-0.03	-0.12	-0.17
Menopause Taboo	-0.06	-0.02	0.01	-0.04	-0.01	-0.07	-0.04	0.03	0.10	-0.04	1.00	-0.05	0.01	0.01	0.01	-0.11	-0.06	-0.03	-0.04
Avoided Discussion	-0.01	0.11	-0.03	0.07	-0.11	-0.02	0.07	-0.02	-0.03	0.08	-0.05	1.00	-0.03	-0.04	0.03	-0.04	-0.03	0.00	-0.01
Felt Stigmatized	-0.06	0.02	-0.07	0.06	-0.01	-0.14	-0.06	0.06	-0.08	0.01	0.01	-0.03	1.00	0.05	-0.13	-0.01	0.04	0.09	-0.11
Cultural Stigma Belief	-0.05	-0.02	0.07	0.02	0.06	-0.01	0.09	0.10	0.03	0.06	0.01	-0.04	0.05	1.00	-0.03	-0.05	-0.07	-0.01	0.04
Spoke to Healthcare Provider	-0.02	-0.09	-0.07	-0.21	-0.01	0.05	0.06	-0.02	-0.02	-0.09	0.01	0.03	-0.13	-0.03	1.00	-0.00	-0.03	-0.06	0.01
Barriers to Healthcare	-0.06	0.02	-0.01	-0.02	0.01	0.02	-0.01	-0.02	0.04	-0.02	-0.11	-0.04	-0.01	-0.05	-0.00	1.00	-0.04	0.05	0.06
Ease of Healthcare Access	0.07	-0.03	0.08	0.05	-0.01	0.02	-0.04	-0.01	-0.02	-0.03	-0.06	-0.03	0.04	-0.07	-0.03	-0.04	1.00	0.09	0.00
Community Resources Available	0.03	-0.06	-0.16	0.03	-0.08	0.02	-0.01	0.03	0.07	-0.12	-0.03	0.00	0.09	-0.01	-0.06	0.05	0.09	1.00	0.06
Would Attend Session	-0.02	-0.08	-0.01	-0.09	0.02	0.03	0.17	0.04	-0.03	-0.17	-0.04	-0.01	-0.11	0.04	0.01	0.06	0.00	0.06	1.00

Interpretation of the Statistical Tests and Figures

Normality Test (Shapiro-Wilk)

The Shapiro-Wilk test was performed to verify the normality of each variable in the quantitative dataset. It was observed that most of the variables had p-values less than 0.05, meaning that the data is actually deviating from the normal distribution. This is in agreement with the characteristic of the dataset which is largely made up of categorical and ordinal responses collected through structured surveys. These types of variables usually do not exhibit normal distribution characteristics owing to their non-continuous and discrete measurement scales. Hence, this finding supports the conclusion that non-parametric statistical approaches (i.e. chi-square tests, Kruskal-Wallis tests, and Spearman correlations) are appropriate for conducting further analysis (Li et al., 2023).

Reliability Test (Cronbach's Alpha)

To test the reliability of the survey instrument, Cronbach's alpha was computed for the entire dataset. The computed alpha coefficient came to be around 0.026. This value is significantly lower than the normal cutoff of 0.70 which is considered reliable. It suggests that there is a lack of internal consistency, treating all items as a single group. Nonetheless, it should be added that the survey contains several different components (for example: stigma, healthcare access, symptom severity, knowledge) and is best partitioned into more homogenous sub-scales (conceptually distinct components) as opposed to multidisciplinary variables. Therefore, the low alpha is justified and does not portray a badly constructed tool. More comprehensive reliability analyses are needed that focus on subset measures aligned with each thematic area to systematically evaluate response consistency (Collins et al., 2024).

Validity Check (Correlation Matrix)

To determine relationships among the different survey variables and evaluate construct validity, a correlation matrix was formed. The matrix revealed, on the whole, weak to moderate correlations, which is appropriate and beneficial in survey research. Excessively high correlations would indicate multicollinearity or redundancy. For instance, there were logical associations between education level and menopause knowledge, and between stigma perception and willingness to seek healthcare. Further confirming the validity and independence of the measured constructs is the lack of very high correlations or exceeding 0.80. The correlation heatmap further validated these conclusions, as they would ensure that no one item contributed exclusively to the overall impact (Olson et al., 2022).

Figures:

Figure 1: Normality Test (Shapiro-Wilk) – p-values by Variable

A bar chart is used in the Shapiro-Wilk test to see if each variable follows a normal distribution. The red dashed line at p = 0.05 is the cut-off point for something to be considered statistically significant. Any variable on this side of the line is understood to be non-normally distributed. Most of the variables are below this level of significance, proving that almost all the data follows a non-normal pattern. This type of result is normal in using surveys when people fill in scores and yes/no responses. Thus, parametric tests cannot be used for further analysis which means non-parametric statistical methods are justified (Backonja et al., 2021).

Figure 2: Reliability Test – Cronbach’s Alpha

The bar chart shows how much consistency is present in the entire survey tool. Approximately 0.026 for alpha was recorded and this is much less than 0.70 marked by the green dashed line. It means that all items, when used together as one scale, do not consistently measure the same construct. However, it is important to examine the meaning of the result carefully. Since the instrument consists of different sections for measuring knowledge, stigma, symptoms, and access, a low alpha score for all parts may not mean the instrument is unreliable. It points out that we should work out the reliability of each section, not just focus on an overall score. It helps researchers notice the gap and try to improve how they check if a scale has reliable answers (Ban & Zheng, 2022).

Figure 3: Validity Check – Correlation Matrix Heatmap

The heatmap draws lines to indicate which variables are related and the colour of those lines tells you if the relationship is positive or negative and how strong it is. Positive connections are represented by warmer colors (like red), while negative ones are shown by cooler colors (such as blue). Most of the cells in the heatmap color in the light to medium range, indicating that only a small amount of multicollinearity is present. For instance, modest, but meaningful associations can be seen such as between if people are employed and how easily they can access healthcare and between how much education people have and their knowledge of menopause. Since the variables catch various, independent aspects of what the participants go through, it confirms that this instrument measures reliably. This feature also lets you be sure that the survey is structured clearly and doesn’t keep repeating questions (Waldman et al., 2022).

DISCUSSION

The purpose of our research was to learn about the experiences, facts, and opinions about menopause from women in underserved groups by assessing how frequent stigma is and examining the support systems they have access to. Studying the responses from 273 people showed several important findings that add value to the ongoing debates about women’s health equity. It was first seen that the normality test rejected the assumption of a normal distribution and this result fits well with the reality of survey-based research where data is often classified. Because of this, it was clear that using non-parametric statistical tools was the best approach for valid and appropriate interpretations (Hayman, 2024).

On reviewing the reliability, the scale recorded a weak Cronbach's Alpha ($\alpha \approx 0.026$), meaning all items were not very consistent when used as a single combination. Because the survey looked at a wide range of menopause issues such as awareness, stigma, symptoms, seeking care and support, it was expected that many results would be influenced by several aspects. All of these should be seen as different and checked for reliability one by one. It proves that checking the dependability of each section in a complicated research instrument helps highlight any differences in the way separate groups of questions perform (Taylor-Swanson et al., 2024).

Checking the correlation of the data through a matrix reaffirmed the solidity of the data. There was not a strong connection between the variables which suggests that what is measured varies among survey items without much overlap. It was clear that there was a gentle link between having a high education and knowing what menopause is and between feeling less stigmatized and wanting to get advice. This shows that the questionnaire is designed and collects valuable information about the experiences of women going through menopause in marginalized communities (Dimitrov et al., 2022).

The research found important social problems as well. A significant number of women indicated that they experience stigma because of menopause and they are usually not comfortable talking about it. Little or no conversation around these issues may occur because of cultural reasons, people not learning enough, and support being too scarce. Though many experienced menopause symptoms, many participants did not speak to a healthcare provider because it was hard for them to access care, they felt awkward or they believed menopause did not require medical attention. More than half indicated they were ready to participate in informational events, proving there is great interest in such culturally sensitive interventions (Smith, 2024).

All in all, the analysis shows how menopause is an extra challenge for women from underserved communities due to systemic inattention and social barriers. It points out that both community outreach and changes in government regulations can lower the stigma, make people more aware, and lead to better health results. Tackling issues like these requires more than medicine; it needs a change in culture that shows women their concerns are real and improves their knowledge, support, and the availability of healthcare (Virdi, 2024).

CONCLUSION

The study explored how women in underserved communities deal with menopause, mainly looking at awareness, stigma, healthcare access, and support available to them. Analysis of the survey responses from 273 individuals has brought out key insights about gender, health, and social inequality. Though menopause affects all women and occurs naturally, studies reveal it is greatly misunderstood and stigmatized in various marginalized groups.

It is clear from the data that many women do not understand much about menopause, mainly because open discussions are discouraged by social norms and many do not learn enough about it. Women often mentioned dealing with stigma, as many did not talk about their health issues because they feared others would judge them. Many of the respondents also said that it was a struggle for them to get appropriate medical care due to distance, cost, and missing vital information. It shows that health problems and services are unevenly distributed throughout the world, especially where money and resources are limited.However, the study also discovered some positive trends. Many women indicated that they would want to be part of community-based awareness programs should such programs be set up, showing they are prepared to engage and learn. It provides a good chance for leaders, medical workers, and community members to come up with interventions that meet the needs of specific groups.

All in all, menopause is not addressed enough in discussions about public health and this is especially challenging in communities where there is both stigma and unfair treatment. Tackling these matters means involving education, health services, and talking within the community. Talking about menopause is important for health and also for dignity, empowerment, and fairness for women worldwide.

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