Indigenous Communication and the Circulation of Menopausal Health Information Among Rural Women in Anambra State, Nigeria: An Ethnography of Communication Perspective

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ABSTRACT

Background: Menopause has little place in Nigerian health communication, and little is known about how rural women learn about it. This study examined how menopausal health information circulates among rural women in Anambra State: through which channels, from whom, what is said and left unsaid, and how women interpret and act on it.

Methods: Guided by Hymes's ethnography of communication, we conducted in-depth interviews with nine women aged 47 to over 60 in three agrarian, Igbo-speaking communities (Nando, Achalla and Umueze in Anam), supported by brief contextual observation. Data were analysed thematically, with the SPEAKING framework as a sensitizing lens.

Results: Information moved through mothers, age-mates, market conversation and talk at weddings and burials; clinics, radio and town-crier announcements carried almost none. Credibility rested on lived experience and closeness, not office: two women who had led women's groups had never put menopause on their agendas. Menopause was seldom a formal topic but travelled through gossip and metaphor; sexual symptoms and long-term risks went largely unmentioned. Igbo terms such as *Ọpụpụ n'ama* ("coming out to the open square") framed menopause as maturity, relief and entry into senior womanhood; worry attached only to early cessation. Responses mixed chemist drugs, herbs and peer advice, including self-medication for unrecognised symptoms and herbs taken to restart menstruation.

Conclusion: These women were reachable through trusted indigenous channels that carried little accurate menopause information. Programmes should place menopause on existing women's platforms, choose messengers for experience rather than title, and add information on symptoms, early menopause and bone and heart health.

Keywords: menopause; indigenous comm unication; ethnography of communication; health communication; rural women; Igbo; Nigeria

INTRODUCTION

In 2021, women aged 50 and over accounted for 26% of all women and girls globally, up from 22% a decade earlier (World Health Organization [WHO], 2024). Yet, as the WHO (2024) observes, menopause "is often not discussed within families, communities, workplaces, or health-care settings." This silence has consequences. Clinically, natural menopause is confirmed after 12 consecutive months without menstruation and is commonly accompanied by hot flushes, night sweats, poor sleep, vaginal dryness, and mood changes. Declining bone density increases the risk of osteoporosis and fractures, while women's earlier cardiovascular advantage over men gradually diminishes (WHO, 2024). Women at this stage need information that helps them recognize symptoms, understand the support available to them, and identify longer-term health risks (Hajesmaeel-Gohari

et al., 2021).

In Nigeria, many of these information needs are not met through formal channels. A recent national qualitative study found that women received little anticipatory information about menopause, that clinicians were often insufficiently trained to manage it, and that rural women reported greater neglect and heavier reliance on informal care than their urban counterparts (Eleje et al., 2026). Rural women also face barriers associated with literacy, distance from health services, and limited access to digital media (Obaremi & Olatokun, 2022). Rural menopausal women in south-eastern Nigeria therefore fall outside most organized health communication. They are too old to be the primary audience of maternal and family-planning campaigns, are rarely addressed by mass media in accessible languages or formats, and remain underrepresented in research. Public health writing often describes such groups as "hard to reach" (Shaghaghi et al., 2011), a label that places the difficulty in the population rather than in the communication systems intended to reach it (Dutta, 2008). This study treats reach as relational: whether information reaches women depends not only on message delivery but also on the channels and messengers they already trust.

Two bodies of scholarship are relevant to this problem. First, research on menopause in Africa has concentrated largely on symptom prevalence, attitudes, awareness of hormone therapy, and clinical management (Adekunle et al., 2000; Ezeome et al., 2019; Mengue Ngadena et al., 2021), with a smaller qualitative literature on women's lived experiences and indigenous beliefs (Eleje et al., 2026; Makuwa et al., 2015; Rasweswe & Mulaudzi, 2022). Across these studies, one finding recurs: women learn about menopause primarily from friends, relatives, and older women. A meta-analysis of 14 African studies, half of them conducted in Nigeria, estimated that 44% of women consulted friends and 35% consulted relatives, compared with 30% who consulted health providers (Hofnie-Hoëbes et al., 2018). In Enugu, 59% of postmenopausal women attending a gynaecology clinic relied on experiences shared by peers and older women (Ezeome et al., 2019). Research on indigenous communication in Africa has documented the oral, interpersonal, and institutional channels through which communities exchange information, including markets, age grades, town criers, and religious gatherings (Ansu-Kyeremeh, 2005; Soola, 2003; Ugboajah, 1985; Wilson, 1987). Much of this work, however, has focused on development campaigns, political mobilization, and rural development rather than health communication (Nsereka & Adiele, 2013).

Neither literature, however, examines in detail the communication practices through which rural menopausal women actually learn about and discuss menopause. Menopause research establishes that informal sources dominate, but it often treats "friends" and "relatives" as questionnaire categories rather than examining how these channels operate: who may speak within them, in what language, under what social rules, and what remains unspoken. Indigenous communication scholarship has rarely addressed health topics governed by cultural norms and has seldom examined older women's reproductive health. Rural south-eastern Nigeria is also thinly covered. The Enugu evidence comes from a hospital clinic, while the national qualitative study, although it documents rural women's reliance on informal care, was not designed to describe how that care communicates. The communication system on which rural menopausal women depend is therefore acknowledged in the literature but has not itself been studied.

Closing this gap matters to three audiences. Primary health-care planners and non-governmental organisations designing menopause education in south-eastern Nigeria need to know which channels and messengers, rural women trust before deciding where to place information. Leaders of church and community women's associations, who already convene many of these women, need to understand what their platforms communicate and what they omit. For health communication scholarship, the study questions the "hard to reach" label by examining a population to which it is routinely applied.

The purpose of this study therefore, is to describe and interpret how menopausal health information circulates within the indigenous, interpersonal, and community-based communication of rural women in three Igbo-speaking communities in Anambra State, Nigeria. Guided by Hymes's ethnography of communication, the study addresses five research questions:

1. Through which indigenous, interpersonal, and community-based channels does menopausal health information circulate among rural women?

2. Who do rural women regard as credible sources of menopausal health information within these channels?
3. Which aspects of menopausal health are discussed openly, and which are conveyed indirectly through culturally embedded language and communication practices?
4. How do rural women interpret menopausal experiences within these communication settings?
5. How do these communication processes shape rural women's responses to menopausal symptoms in everyday life?

LITERATURE REVIEW

Menopausal Health Information: Needs and Sources

Menopause marks the end of a woman's reproductive years. Most women reach it in midlife, and some before the age of 40 (WHO, 2024). Its symptoms differ from woman to woman and from one setting to another, and so do the information needs it creates, which extend from recognising symptoms and weighing treatment and lifestyle options to emotional support and knowledge of long-term risk (Hajesmaeel-Gohari et al., 2021).

Across settings, the evidence on how these needs are met points one way: interpersonal sources come before formal ones. The meta-analysis by Hofnie-Hoëbes et al. (2018) found friends and relatives to be the most consulted sources in African studies, with health providers, broadcast media and print further behind; the authors warn that the pooled estimates varied widely between studies. In Enugu, Ezeome et al. (2019) found that, although 37% of clinic attenders had sought hospital treatment for menopause and 49% had heard of hormone therapy, mostly from physicians, the majority still relied on what peers and older women told them. Eleje et al. (2026) describe Nigerian women coping through peer networks, faith-based practice and self-management, with rural women more dependent on informal care. Women in Cameroon combined hospital treatment, self-medication and traditional remedies (Mengue Ngadena et al., 2021), and women in Saudi Arabia reported limited knowledge and unmet needs for information and support (AlSwayied et al., 2024). The pattern is sharper in rural settings, where social relationships weigh heavily in health decisions (Obaremi & Olatokun, 2022) and where women tend to seek health information from people they know and trust (Wathen & Harris, 2007).

These studies agree that informal channels carry most menopause information; they differ mainly on how much. None, however, makes the informal channel an object of study. "Friends" and "relatives" appear as response options, and the communicative work done through them (which settings, which speakers, which words and which silences) goes undescribed.

Indigenous Communication: Definitions and Distinctions

Scholars of African communication describe indigenous communication as culturally grounded systems embedded in oral tradition and in kinship and community institutions. Its forms include storytelling, proverbs, songs, women's gatherings, market exchange, age-grade meetings, religious fellowships and everyday encounters, in which meaning is shared through dialogue rather than broadcast from a centre (Ansu-Kyeremeh, 2005; Soola, 2003; Wilson, 1987). Ugboajah (1985) called these forms "oramedia." Three distinctions, blurred in parts of the literature, matter for this study.

First, indigenous is not a synonym for informal or interpersonal. A WhatsApp group of menopausal women is informal and interpersonal but not indigenous; an age-grade or *umuada* meeting is all three. In this study a channel counts as indigenous when it is embedded in pre-existing community structure, relies on oral and embodied transmission, and draws on local language and symbolic systems. Second, indigenous communication can refer to a practice (proverbial speech, storytelling), a channel (the gathering, market or fellowship in which the practice occurs) or a system (the cultural arrangement that makes the practice legitimate). We treat it mainly as a system while attending to the practices and channels through which the system operates. Third, indigenous communication is not simply what fills the space left by formal communication. It has its own logic, gatekeepers and norms of evidence (Nsereka & Adiele, 2013; Soola, 2003), and the rules that govern who may speak, to whom, where and in what words are themselves part of what is communicated (Rasweswe & Mulaudzi, 2022).

Reproductive knowledge within these systems passes through mothers, mothers-in-law, grandmothers, peers and trusted community members more often than through professionals (Hofnie-Hoëbes et al., 2018; Makuwa et al., 2015; Rasweswe & Mulaudzi, 2022). In Igbo society the relevant structures include the *umuada*, the association of a lineage's daughters, which carries considerable social authority (Amadiume, 1987), as well as age grades, church women's organisations and town-wide women's meetings.

Cultural Meanings of Menopause

How women talk about menopause depends on what their communities take it to mean. Symptom reporting and the significance of the transition vary across cultures (Lock, 1993; Melby et al., 2005), and comparative anthropology has long noted that middle-aged women in many societies gain freedom from earlier restrictions and greater authority (Brown, 1982). African studies report more than one reading. In Mamelodi, South Africa, most women over 60 saw menopause as a normal part of ageing, while many younger women held negative views linked to limited information and a taboo on discussing it (Makuwa et al., 2015). Indigenous accounts from southern Africa frame it variously as a passage to wisdom and elderhood or as a loss, and attach particular beliefs and remedies to each (Rasweswe & Mulaudzi, 2022). In Nigeria, menopause is widely treated as a natural stage to be endured, a framing that coexists with stigma and silence within families (Eleje et al., 2026). In Igbo society, gender has long been partly separable from biological sex, so that women can take on statuses usually held by men (Amadiume, 1987). That flexibility bears directly on how the status of a woman past childbearing may be understood.

Indigenous Channels as Both Enabling and Constraining

The literature presents indigenous channels as enabling and constraining at once. They are accessible, culturally legible and built on trust: women receive information from familiar people, in familiar places and in familiar language (Hofnie-Hoëbes et al., 2018; Wathen & Harris, 2007). The same channels carry euphemism, misinformation and silence. Proverb, euphemism and indirect reference make them comfortable to use, yet these resources can also leave some symptoms, sexual ones especially, unsaid (Makuwa et al., 2015; Rasweswe & Mulaudzi, 2022).

Most studies therefore establish that indigenous channels matter but treat them as a black box. We found no study that has documented, for a particular community in south-eastern Nigeria, what menopause information circulates through which channels, where silence falls, who may speak and who may not, and how women interpret what they hear. This study takes up that task.

Theoretical Framework: The Ethnography of Communication

The study draws on Dell Hymes's ethnography of communication (Hymes, 1962, 1974). Hymes developed the approach against accounts of language that separated grammar from use, arguing that communicative competence includes knowing how, when, with whom and in what way a language may appropriately be used. The approach rests on four propositions: communication is patterned and rule-governed; its rules are culturally specific and largely tacit, shared within a speech community; meaning cannot be separated from social context; and what a community leaves unsaid is as patterned as what it says (Saville-Troike, 2003). Its basic unit of analysis is the speech event, examined through eight components that Hymes (1974) summarised in the acronym SPEAKING: Setting and scene, Participants, Ends, Act sequence, Key, Instrumentalities, Norms of interaction and interpretation, and Genre.

Within this tradition, silence is a communicative act with its own forms and functions. Basso (1970) showed that Western Apache speakers fall silent in specific, socially defined situations, and Saville-Troike (1985) argued that silence should be analysed alongside speech within one framework. For this study the point is practical. When a topic is missing from formal women's meetings, the absence may itself be a rule of the speech community.

The framework suits a study of menopause because what the community regulates is less the information itself than the communicative code around it. Whether menopause is discussed, where, by whom, in what tone, through which instruments (Igbo proverb and euphemism more often than biomedical vocabulary) and under what norms,

especially those concerning sexuality, all vary with setting and participants. The SPEAKING components shaped the interview guide and served as sensitising categories during coding, so the framework runs through the whole analysis.

One limit should be stated at the outset. The ethnography of communication usually studies speech events as they happen. In this study most speech events are reconstructed from women's accounts, supplemented by brief observation of the settings they named. We therefore use the framework to structure inquiry into women's reports of communicative practice, and we return to this limit in the Discussion.

METHOD

Design

This qualitative study, informed by Hymes's ethnography of communication, used in-depth individual interviews supported by brief contextual observation. It did not use focus group discussions. Reporting follows the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007).

Setting

Fieldwork lasted more than one month, in three agrarian, Igbo-speaking communities in Anambra State: Nando (Anambra East Local Government Area), Achalla (Awka North) and Umueze in Anam (Anambra West). The communities were chosen because the settings in which menopause talk was expected to occur, namely women's associations, markets, churches and kinship networks, are active in. Women in these communities meet in the *umuada*, in age grades, in church women's organizations such as the Catholic Women Organization (CWO), in Pentecostal fellowships, and at the August Meeting, an annual gathering of a town's women organized largely through the churches. Development unions such as the Umueze Anam Development Union (UDU) also hold general meetings.

Participants and Sampling

Nine women were recruited through purposive sampling with snowball referral**,** the first referral was through one of the research assistants who is a native of Umueze, then the interviewees suggested candidates based on their position or experience in the community: five in Umueze in Anam, two in Nando and two in Achalla. Eligible women were aged 45 to 65, had gone at least 12 consecutive months without menstruating or were experiencing perimenopausal symptoms, had lived in the community for at least five years, and gave informed consent. Menopausal status was self-reported. Sample size was guided by information power (Malterud et al., 2016): the aim was narrow, the participants were closely matched to it, the analysis drew on an established framework, and interviews were held in the participants' first language. The last two interviews added no new channels or meanings.

Table 1 summarizes the participants. They varied in age (47 to over 60), formal education (none to a first degree), occupation (traders, farmers, a teacher and a civil servant), marital status (six widowed, three married) and religion (Catholic, Pentecostal and other Christian affiliations, and one traditionalist). Four had no formal schooling. Most named mothers, peers or market women as their first or main source of menopause information; the two women with tertiary education (P4 and P5) were the only ones whose sources were wholly formal.

Table 1 Participant Profile

ID	Community	Age	Marital status	Education	Occupation	Religion and role	Reported onset of menopause	First or main source
P1	Umueze in Anam	56	Widowed	Commercial school	Trader and farmer	Christian; PFN and CWO member	Early 50s	School and mother

P2	Umueze in Anam	49	Married	None	Trader	Pentecostal	More than a year before interview	Market women
P3	Umueze in Anam	57	Widowed	None	Farmer	Traditionalist	About 48	Peers
P4	Umueze in Anam	62	Widowed	HND	Civil servant	Christian; community women's leader	45	School (biology)
P5	Umueze in Anam	60	Married	B.A.Ed.	Teacher	Christian; church leadership role	About 50–51	School and church
P6	Nando	Over 60	Widowed	None	Retired farmer	Pentecostal	Not established	Mother
P7	Achalla	Over 60	Married	None	Farmer	Catholic	Late 30s or early 40s	Mother
P8	Achalla	47	Widowed	Secondary	Trader	Pentecostal	Recent	Market women
P9	Nando	64	Widowed	Class 3	Farmer	Catholic; former women's group leader	About 52–53	Peers and mother

Note. N = 9. Ages and onset are as reported by participants. CWO = Catholic Women Organisation; PFN = Pentecostal Fellowship of Nigeria; HND = Higher National Diploma; B.A.Ed. = Bachelor of Arts in Education. "None" means no formal schooling. Village names, specific leadership posts and places of origin are withheld to protect anonymity.

Data Collection

Interviews followed a semi-structured guide built around the SPEAKING components, with prompts on settings, participants and authority, communicative codes (direct speech, proverb, euphemism and silence), content, interpretation and response. The guide was piloted with two women outside the sample and revised. Individual interviews were preferred to focus groups because menopause is personal and culturally sensitive, and women might not disclose in a group (Gill et al., 2008). Interviews were conducted in Igbo, with some switching into English, lasted 25 to 40 minutes and were audio-recorded. Interviews took place in their houses, church and market as the situation warranted

Contextual observation served to understand the settings in which participants said menopause was discussed, not to record menopause talk as it happened. In Umueze in Anam, the first author visited the market on a market day, walked through it and observed how women interacted. The first author also visited an Anglican church in Umueze Anam outside service time and spoke with the reverend's wife, one of the nine participants. Field notes recorded the setting, who was present and how people spoke. No personal disclosures were recorded.

Transcription and Translation

Recordings were transcribed and translated into English by the first author, a native Igbo speaker, every interview was transcribed in full. Igbo terms central to the analysis, such as *Ọpụpụ n'ama*, *nwanyị akazụgo* and *ikwụsị ịhụ nsọ*, are kept in Igbo with English glosses, because a single English word would lose their meaning (Temple & Young, 2004). Where a meaning was uncertain, it was checked with the research assistants In the Findings, words spoken by participants appear in quotation marks; statements recorded in field notes or summarized by the researcher are reported as paraphrase.

Data Analysis

We analyzed the data thematically following Braun and Clarke (2006), combining deductive and inductive coding (Fereday & Muir-Cochrane, 2006). The SPEAKING components supplied sensitising categories: channels and setting, participants and authority, content and silences, codes and norms, and interpretation and

response. Within these, codes were built inductively. Repeated reading of transcripts and field notes produced initial codes from recurring expressions and experiences; related codes were grouped into categories; and the categories were refined into five themes, each answering one research question. Coding matrices and analytic memos supported the work, particularly for indigenous expressions, silences, euphemisms and culturally specific meanings. Table 2 traces representative codes to their categories and themes.

Table 2 Development of Codes, Categories and Themes

Representative codes	Category	Theme
Symptoms interpreted through market talk; maternal transmission, direct and indirect; ceremonies as communicative sites; mobilisation instruments without health content; near-absent mass media	Everyday networks	Theme 1: Menopausal health information circulates through interpersonal, indigenous and community-based networks
Maternal and peer credibility grounded in lived experience; advice from older to younger women; leadership position not equivalent to communicative authority; leaders' distance from the village	Authority and credibility	Theme 2: Credibility and influence rest on experience, relational closeness and social position
"Not discussed openly" (P1, P2, P3, P6); content gap in women's organisations (CWO, PFN, August Meeting); gossip as an indirect channel; distance from village networks	Selective and indirect communication	Theme 3: Menopause is rarely discussed openly and is often expressed indirectly
Core definition (*ikwụsị ịhụ nsọ*); *Ọpụpụ n'ama* and terms of maturity; *dịka nwoke* as status rather than sex; folk-physiological explanation; largely positive framing; worry about early onset	Indigenous meaning-making	Theme 4: Women interpret menopause through indigenous frameworks of maturity, relief and transition
Shared symptom vocabulary; misrecognition followed by self-medication; herbal and English medicine combined; herbs to restart early cessation; hybrid reproductive care as precedent	Hybrid knowledge and response	Theme 5: Communication processes shape hybrid responses to menopausal symptoms

Note. CWO = Catholic Women Organisation; PFN = Pentecostal Fellowship of Nigeria.\

Rigour

We assessed rigour against Lincoln and Guba's (1985) criteria, using strategies described by Shenton (2004). Credibility was supported by comparing accounts across the three communities and across interviews and observation; because the observation was brief, this triangulation is modest. Member checking was carried out by returning summaries depwndently in Igbo. Dependability was supported by an audit trail of methodological and analytic decisions. Confirmability was supported by debriefing with two external qualitative researchers who were not involved in the study, and by a reflexive journal. Transferability rests on the account of the settings, the participant profile in Table 1 and the extended participant extracts in the Findings.

Researcher Positionality

The first author, who conducted the fieldwork is Igbo and a native speaker of the language, which helped in following proverbs, metaphor and indirect expressions and in building rapport. She was born into an Igbo community but does not live in the study communities, so she was partly an insider, sharing language and culture, and partly an outsider, as a university-based researcher. Two research assistants, indigenes of Umueze in Anam and Nando, supported the fieldwork. They did the necessary introductions, note taking, and interviewing on few occasions. Their presence encouraged openness, The first author kept a reflexive journal to record how these relationships may have shaped what was said and how it was interpreted.

Ethical Considerations

All ethical compliances were dully followed according to Helsinki ethics committee. Community entry was negotiated through community natives and local women's leaders, and community leaders agreed to the

observation. Before each interview, the purpose of the study was explained in Igbo and participants gave informed verbal consent. They were assured of confidentiality and anonymity, told they could decline any question and told they could withdraw at any time without consequence. Participants are identified by codes (P1 to P9). Because the communities are small, details that could identify a woman, such as a village name, a leadership post held in a particular community or a place of origin, have been removed or generalised in Table 1 and the Findings. Recordings and transcripts are stored.

FINDINGS

The analysis produced five interrelated themes, one for each research question. Table 3 first summarises how the eight SPEAKING components appeared across the nine accounts.

Table 3 SPEAKING Components Reflected in the Data

Component	What it captures	Evidence from this study
Setting and scene	Where communication occurs	Markets; weddings and burials; family compounds; venues of the CWO, PFN and August Meeting; church conferences; the village square; town-crier routes
Participants	Who speaks and who listens	Mothers, mothers-in-law, elder sisters, age-mates (*ndị ọgbọ*), market women, older women, church women's leaders, traditional birth attendants (*ndị na-ana nwa*), town criers
Ends	Purposes of communication	Explaining symptoms, reducing fear, advising younger women, interpreting fertility status, warning about early menopause, normalising menopause
Act sequence	Order of a typical exchange	A woman notices symptoms; asks a mother, peer, market woman or elder; receives an explanation or advice; interprets the experience; chooses a response
Key	Tone or manner	Private advice, reassurance, joking, gossip, metaphor, indirect speech, serious warning
Instrumentalities	Language, channels and forms	Igbo and its local varieties, with some English; *Ọpụpụ n'ama*; *nwanyị akazụgo*; *ekwe*, *ọjà* and *ogene*; town criers; church health talks; Radio Sapientia
Norms	Rules of speech and silence	Menopause is not shameful but is rarely a formal agenda item on women's platforms; sexual symptoms and long-term risks are largely avoided
Genre	Type of speech event	Gossip, advice, testimony, metaphor, health talk, maternal instruction, peer discussion, community announcement

Note. CWO = Catholic Women Organisation; PFN = Pentecostal Fellowship of Nigeria. *Ekwe* = slit drum carved from a hollowed log; *ọjà* = wooden flute; *ogene* = metal gong.

Two features of Table 3 run through the themes that follow. Almost every setting and participant is domestic, commercial or ceremonial; health institutions appear only at the edges, through church health talks and a single radio station. And the Norms row marks the limit of the system: menopause itself could be talked about, but sexual symptoms and long-term health risks fell outside what was usually said.

Research Question 1: Channels of Circulation

Theme 1: Menopausal Health Information Circulates through Interpersonal, Indigenous and Community-Based Networks

For most participants, menopausal health information did not come from clinics, radio or organised health campaigns. It moved through mothers, peers, market conversation and ceremonial gatherings. The market was a particularly active site of learning, especially for traders who first took their own symptoms for illness. P2, a

49-year-old trader in Umueze in Anam, had hot flushes, night sweats and insomnia for more than a year before she understood what was happening. Her blood pressure was normal, so she went to a chemist for sleeping drugs. Only through conversation with other women did she come to see her experience as menopause: "Women discuss about it in the market." P8, a 47-year-old trader in Achalla, described an almost identical path, saying she came to understand menopause in the market once she herself was affected. For these two traders the market worked as an interpretive community, a place where an unexplained bodily change acquired a name.

Mothers passed on knowledge in more than one form. For P6, an older Pentecostal widow and retired farmer in Nando, the teaching was direct: "*Nne'm kụziri mu*" ("My mother taught me"). For P9, a 64-year-old Catholic farmer in Nando, it came as a saying: "*Oge nwanyị na-aga aga*" ("A woman's season passes gradually"), which she took to mean that menstruation was a passing phase. Both women learned from their mothers, but one received explicit instruction and the other a saying she had to interpret for herself. The same relationship carried two different communicative codes.

Ceremonies served as communicative spaces as well as social ones. P7, a Catholic farmer in Achalla, described how women gather at weddings and burials, gossip, laugh, and use the occasion to advise younger wives. P8 recalled the kind of talk that circulates when a bride is thought older than expected:

"*Ọ ga-atụzịkwa ime? Ọ ga-amụtazikwa nwa? Ọ kazụgo; ọ banye go* menopause." ("Will she still conceive? Will she still be able to give birth? She has matured; she has entered menopause.") (P8)

This kind of discussion is not organized health education, yet it circulates working knowledge about age, fertility and reproductive status among the women present. The English word *menopause*, set inside an Igbo sentence, also shows that the biomedical label has entered village talk even where biomedical content has not.

Formal sources formed a smaller, distinct pattern. P4, a 62-year-old civil servant with a Higher National Diploma, first heard of menopause in a school biology class. P5, a teacher with a first degree who is closely involved in church leadership, credited school, church seminars and books, and said explicitly that she had not learned it from her mother. P1 named school alongside her mother. P4 and P5 were the only participants whose sources were wholly formal, the only two with tertiary education, and both described themselves as removed from village-based talk about menopause. With two cases the pattern can only be suggestive, but it raises the possibility that education orients women toward particular channels.

Community mobilization instruments were active channels for general information but not for this subject. Several participants mentioned the town crier, the *ekwe* (a slit drum carved from a hollowed log), the *ogene* (a metal gong) and communal drumming and announcement. None of the accounts described these instruments carrying menopause content; they call people to meetings and events, not to health information. Mass media were almost absent. Only P8 mentioned a specific outlet, Radio Sapientia. P6 neither owned nor listened to a radio, and the other women could not recall meeting menopause information in broadcast media.

For these women, then, menopausal health information travelled mainly through mothers, peers, market conversation and ceremonial gossip. Formal institutions and mass media played a small part, and the indigenous mobilization instruments, though active, did not carry this content.

Research Question 2: Credible Communicators

Theme 2: Credibility and Influence Rest on Experience, Relational Closeness and Social Position

Participants did not describe menopause information as something dispensed by designated experts. The women they regarded as credible had lived through menopause themselves, were close to them, or held a recognised social position; health training was not part of the description.

Mothers were the most consistently trusted source. What gave them influence was lived experience and closeness, the same qualities that made peers and age-mates credible. P9 said her peers were her first source,

with her mother's contribution coming later and indirectly. P7 explained that age-mates (*ndị ọgbọ*) talk about menopause because they share the same stage of life:

"*Anyị gbaakọ dịka ndị ọgbọ... anyị ekwuo okwu maka ọpụpụ n'ama.*" ("When we gather as age-mates... we talk about menopause.") (P7)

Credibility also flowed from women who had completed the transition to those approaching it. P7 described older women using ceremonies to advise younger wives, their authority resting on experience.

Formal leadership did not reliably translate into authority on this subject. P4, a community women's leader, and P9, a former leader of a church women's organization, both held recognized positions among women, yet both said that menopause was never discussed formally under their own leadership. P9 was direct: while she led the organization, menopause never appeared as an agenda item. In these two accounts, the standing to speak about menopause and authority over a women's platform were different things, and holding the second did not confer the first.

Distance could weaken leadership's reach further. P6 noted that the women's leader in her area "doesn't reside in the village," a practical fact that limits how far any recognized authority can act as a communicator on the ground.

The credible communicators in these accounts were mothers, peers and older women who spoke from experience and closeness; formal titles counted for little. The distinction bears directly on how programmes choose community messengers.

Research Question 3: What Is Said and What Is Left Unsaid

Theme 3: Menopause Is Rarely Discussed Openly and Is Often Expressed Indirectly

Participants did not treat menopause as hidden or shameful, but it was seldom a standing topic on formal community platforms. Four women in two communities (P1, P2, P3 and P6) each said, in close variants of the same phrase, that menopause is "not discussed openly" where they live.

The gap was clearest on formal women's platforms. P1 belonged to the PFN but said its women had not yet been taught about menopause. P4 said the CWO did not discuss it, although general health talks sometimes took place at the August Meeting and at UDU gatherings. P6 described the August Meeting as a place where women "teach things," but not menopause. P7 attended both the August Meeting and the CWO, and neither addressed it. P9's account is the clearest evidence: even under her own leadership, menopause never became a formal subject. Five women across all three communities thus described the same pattern. Women's organisations existed, met regularly and dealt with welfare and development, but menopause was not on their agendas.

What could be said, and to whom, followed a pattern. Symptoms and personal experience were discussed fairly freely among trusted peers. Sexual changes and long-term health risks were largely absent from the accounts, and only one participant mentioned a long-term condition. Some of what looked like an absence of communication was a different genre of it. Gossip at weddings and burials carried real content about menopause, fertility and age, as P8's example under Theme 1 shows, and P7 described women "laughing over it" at gatherings before they dispersed. This is communication about menopause, conducted in an indirect, informal register rather than a direct, instructional one.

Access to even this indirect talk was uneven. P2 and P6, both Pentecostal, and P5, closely tied to church leadership, described themselves as removed from village discussion. Two said so explicitly ("I just do my business," P2; "I have not had that conversation with anyone," P5), and for P6 church attendance had replaced village meetings. Selective communication therefore worked along two axes: what was said and what was left unsaid, and who stood inside or utside the networks where indirect talk took place.

Symptoms and personal experience, in short, were shared among trusted peers, while the topic as a whole rarely reached formal women's platforms and surfaced instead through gossip, metaphor and indirect speech.

Research Question 4: Interpreting Menopause

Theme 4: Women Interpret Menopause through Indigenous Frameworks of Maturity, Relief and Transition

Participants in all three communities drew on a shared vocabulary, though some elaborated it far more than others. The most common definition, used in some form by five of the nine women, was *ikwụsị ịhụ nsọ*, "to stop seeing one's period." The idiom draws on *nsọ*, a word that also denotes what is set apart or forbidden, a sense that the ritual restrictions described below make concrete. Several women extended the definition into a statement about reproductive completion. P4 tied it to having finished childbearing: "*Ọ mụchago ụmụ... ọ nweghị ike ịmụkwa nwa ọzọ*" ("She has finished bearing children... she can no longer bear another child"). P6 likewise understood menopause as the end of childbearing.

The fullest elaboration came from P6, P8 and P9, who each used the expression *Ọpụpụ n'ama*, literally "coming out to the open square." P9 gave the most developed gloss. The woman, she said, has moved beyond "*ihe e ji amata nwanyị*" (what marks a woman as a woman, that is, reproductive womanhood) and become "*onye chizuru echizu*" (one who has completed her stage well). She likened the change to graduating into a higher class: a woman completes the reproductive stage and enters elderhood, or senior womanhood. P7 used *ọpụpụ n'ama* in passing (see Theme 2) but described the status mainly through the related terms *ịkazụgo* and *nwanyị akazụgo*, both meaning maturity or having come of age. All four women who used the expression lived in Nando or Achalla.

The transition had social consequences as well as symbolic ones. P7 and P9 both described the menopausal woman as "*dịka nwoke*" ("like a man"), and both explained, without being asked, that this meant freedom from menstrual restriction and access to spaces and roles closed to menstruating women, not literal masculinity. P9 described a woman as newly free to enter the village square as a man would. P6 named one such restriction: a woman who has not reached *Ọpụpụ n'ama*, that is, a woman still menstruating, may not cook for her husband or for a *dibia* (traditional healer), whereas a menopausal woman is free of the rule. P7 described a parallel rule: a menstruating woman cannot enter certain shrine spaces because "*ọ dịghị ọcha*" ("she is not clean"), while a menopausal woman may.

Two participants, P6 and P8, offered a shared folk-physiological account of why menopause brings symptoms at all. Menstrual flow, they explained, carries sickness out of the body; once the flow stops, the sickness it would have expelled stays and troubles the woman, producing heat, weakness and restlessness. The account is coherent on its own terms, and women used it to make sense of what they felt.

Framing was mostly positive or neutral. Eight of the nine women described menopause as relief, joy or simply a normal process, and none described it as shameful. Worry attached to one circumstance only: early cessation. P2, P3 and P6 each raised it, and their concern was for childbearing, since a woman who stops "too soon" may not yet have completed the family she intended.

These women therefore read menopause less as a medical event than as a socially meaningful transition. Arriving at the expected time, it signalled completion, maturity and relief; arriving early, before childbearing felt complete, it caused anxiety.

Research Question 5: Responding to Symptoms

Theme 5: Communication Processes Shape Hybrid Responses to Menopausal Symptoms

Women's responses to symptoms drew on indigenous explanation, peer advice, chemist purchases and, occasionally, hospital or church-linked care, and seldom on any one source alone. The symptom vocabulary was consistent across the three communities: heat, night sweats, insomnia and headache appeared in six of the nine accounts. P7 was the only participant to mention longer-term conditions, naming arthritis and osteoporosis alongside weakness.

Misrecognition followed by self-medication recurred. P2, as noted, treated more than a year of hot flushes, night sweats and insomnia as ordinary sickness and bought sleeping drugs from a chemist before market conversation recast her experience as menopause. P3 followed a similar path: she did not connect her body heat and leg pain to menopause until her peers explained it. In both cases peer networks did more than offer support; they were the means by which an unexplained physical experience became a named condition.

The combined use of herbal and Western ("English") medicine appeared explicitly in two accounts. P7 said she used both English medicine and herbs for her own symptoms. P6 described taking indigenous and English drugs together and was confident of their combined strength, though she described this as her general health practice and did not tie it to menopause. P1 described how traditional birth attendants (*ndị na-ana nwa*) in her community already combine herbal remedies with Western antenatal practice, which suggests that this hybrid logic runs through reproductive health care in these communities more generally.

Menopause was not always treated as fixed. P7, who herself reported reaching menopause in her late thirties or early forties, described a specific practice: if menstruation stops abruptly before a woman has finished childbearing, herbs are given to restart her cycle. Indigenous knowledge here is more than explanation. It includes deliberate intervention when menopause arrives earlier than a woman's reproductive plans allow.

The five themes show that the women in this study were embedded in active, meaningful communication systems, interpersonal, indigenous and community-based, through which menopause was named, interpreted and acted on. What remained underdeveloped was menopause as a deliberate, sustained subject on the formal platforms, among them the CWO, the PFN and the August Meeting, that already reach these women.

DISCUSSION

This study set out to describe how menopausal health information circulates among rural women in three Igbo-speaking communities, and what the communication systems involved carry and leave out. Its central finding is that these women were not hard to reach. They lived inside functioning, trusted communication systems made up of mothers, age-mates, market conversation, church platforms and ceremonial gatherings. What those systems lacked was accurate, sustained menopause content. Five findings support this conclusion, and we discuss them in turn.

Reachable Women, Under-Used Channels

Menopause information reached these women almost entirely through interpersonal and indigenous channels.

The finding agrees with meta-analytic evidence that friends and relatives outrank health providers as sources of menopause information in African settings (Hofnie-Hoëbes et al., 2018), with clinic data from Enugu (Ezeome et al., 2019) and with the report that rural Nigerian women lean more heavily on informal care than urban women (Eleje et al., 2026). It also fits wider evidence that rural health information follows trust and social relationships more than institutional proximity (Obaremi & Olatokun, 2022; Wathen & Harris, 2007).

Those studies count sources. This one shows what a source does. For P2 and P8 the market was more than a place where formal information was missing: it was where an unexplained bodily change first became recognizable and nameable. One likely reason is that markets bring together women of similar age who see one another often and talk while they work, so that a symptom described by one woman can be matched against the experience of others. The market, on this evidence, functions less as a gap in the health system than as a site of collective interpretation that health communicators have largely overlooked.

The finding complicates the "hard to reach" framing (Shaghaghi et al., 2011). Access existed; menopause content did not. Dutta (2008) argues that such labels locate the deficit in marginalized communities rather than in the structures that fail to engage them, and these accounts give that argument a concrete case. A rival reading deserves weight, however. Snowball referral reaches women who already know one another, so the sample may overstate how connected rural menopausal women are. The accounts of P2, P5 and P6, who stood at the edge of

village talk, show that the networks do not reach everyone, which is itself a reason against relying on any single channel. The finding on mobilization instruments points the same way. Town criers, the *ekwe* and the *ogene* have long been proposed as channels for development messages (Ugboajah, 1985; Wilson, 1987), and in these communities they were active, but they carried nothing about menopause.

Communicative Authority Is Not Institutional Authority

Credibility on menopause rested on lived experience and closeness; office counted for little. This agrees with evidence that rural women trust people who share their circumstances (Wathen & Harris, 2007) and that friends and relatives are consulted more than providers (Hofnie-Hoëbes et al., 2018). The present data add a distinction those studies did not draw: between institutional authority over a women's platform and communicative authority on a sensitive subject. The two leaders in the sample held the first but had not exercised the second.

The ethnography of communication offers an explanation. In SPEAKING terms, the Participants component allocates the right to speak on a topic, while Norms and Genre govern what a speech event may contain (Hymes, 1974; Saville-Troike, 2003). A CWO meeting or an August Meeting is a formal, public event whose usual genres (announcements, welfare, development and prayer) leave little room for talk about the body, and a leader presiding over it speaks within those genres. Personal talk about menopause belongs to other events, such as a conversation among age-mates or advice given at a wedding. Because the evidence comes from two leaders, the distinction should be treated as a proposition to test. Its practical implication is nonetheless clear: a list of recognized women leaders is not a map of effective messengers.

Silence as Register and Silence as Gap

Menopause was seldom a formal topic, travelled through gossip and metaphor, and left sexual changes and long-term risks largely unspoken. These findings echo reports that menopause is little discussed in families, communities and health services (WHO, 2024), that stigma and silence surround it in Nigerian families (Eleje et al., 2026), and that a taboo on discussing it limits South African women's information (Makuwa et al., 2015).

The ethnography of communication treats silence as patterned communication (Basso, 1970; Saville-Troike, 1985), and the data suggest that two kinds should be distinguished. The first is a shift of register. Menopause as a topic moved out of formal genres and into gossip, joking and metaphor at ceremonies, where its content still travelled; P8's wedding gossip, with the English word *menopause* set inside an Igbo sentence, shows the biomedical label crossing into this register without its biomedical content. The second is silence in the full sense. Sexual changes and the long-term risks to bone and heart were missing from every register the women described. The first kind of silence is a channel to work with, the second a gap to fill. Adding formal health talks to CWO or August Meeting agendas would address the formal gap but could miss the registers where talk already moves, and would not by itself reach the topics that no register carries.

Menopause as Completion

Participants framed menopause as maturity, relief and entry into senior womanhood, and the idiom *dịka nwoke* named a gain in status. The positive framing resembles that of older women in South Africa (Makuwa et al., 2015) and the Nigerian view of menopause as a natural stage (Eleje et al., 2026), but it goes beyond endurance: these women described something gained as well as something accepted. It contrasts with accounts in which menopause signals a loss of femininity or worth (Rasweswe & Mulaudzi, 2022). The "like a man" idiom fits Brown's (1982) observation that women in many societies gain freedom from restrictions in midlife, and Amadiume's (1987) account of an Igbo gender system in which status can be detached from biological sex. Participants were explicit that *dịka nwoke* named a status, not a body. Freedom from menstrual restrictions on cooking, shrine entry and access to the village square is a tangible social gain, and it may help explain why the framing was so positive. Two other explanations cannot be excluded: women may have presented a favourable picture to an educated interviewer, and most participants were well past the transition, which in South Africa was associated with more positive views (Makuwa et al., 2015).

The folk-physiological model offered by P6 and P8, in which menstrual flow expels sickness that remains once the flow stops, is best read as an instance of the cultural shaping of symptom meaning (Lock, 1993; Melby et

al., 2005) rather than as a misunderstanding to be corrected. It is not accurate in biomedical terms, since the symptoms reflect falling ovarian hormone levels, but it links the right symptoms to menopause and, in these accounts, led to no harmful action. The worry about early cessation points to a real risk for a different reason. Early and premature menopause are associated with higher long-term risks of cardiovascular disease and of osteoporosis and fracture (Svejme et al., 2012; Zhu et al., 2019), risks that the women's concern, centred on childbearing, did not include.

Hybrid Responses and Their Risks

Women combined chemist drugs, herbs and peer advice, consistent with findings from Cameroon (Mengue Ngadena et al., 2021), with Nigerian women's reliance on self-management and faith-based coping (Eleje et al., 2026), and with earlier accounts of Nigerian women's perceptions of menopause (Adekunle et al., 2000). This study adds one detail. P7 described herbs given to restart menstruation that had stopped before childbearing was complete, an attempt to negotiate with the body's timeline that goes beyond coping with its aftermath.

Hybrid practice is not uniformly safe, and the communication systems documented here shape which risks women take. Table 4 compares the beliefs and practices reported in this study with biomedical evidence. The sorting is ours. It rests on the sources cited, concerns beliefs and practices only, not any individual's care, and is offered to guide message design.

Table 4 Beliefs and Practices Reported by Participants Compared with Biomedical Evidence

Belief or practice	Reported by	Biomedical comparison	Assessment
Menopause is a normal stage and a sign of maturity and relief (*Ọpụpụ n'ama*, *nwanyị akazụgo*)	Eight of nine participants	A natural life stage that marks the end of the reproductive years, not a disease (WHO, 2024)	Accurate; a strength to build on
Menopause ends childbearing (*ikwụsị ịhụ nsọ*)	P4, P6	Natural menopause is confirmed after 12 months without menstruation and ends the reproductive years (WHO, 2024)	Accurate
Menstrual flow carries sickness out; once it stops, retained sickness causes heat, weakness and restlessness	P6, P8	Symptoms arise from declining ovarian hormone (oestrogen) levels (Hajesmaeel-Gohari et al., 2021; WHO, 2024)	Not accurate in biomedical terms, but links the right symptoms to menopause and is low-risk; a different explanatory model
Hot flushes, night sweats and insomnia treated as ordinary illness, with sleeping drugs bought from a chemist	P2; P3 did not link body heat and leg pain to menopause until peers explained	These are typical menopausal symptoms (WHO, 2024); sedatives taken without supervision carry risks and can mask other conditions	Potentially harmful; follows from an information gap rather than a belief
Herbs given to restart menstruation that stops before childbearing is complete	P7	Menstruation that stops before 40 may signal premature menopause, which has medical causes (WHO, 2024) and needs clinical assessment; the safety and effectiveness of unregulated herbal products are not established (Ekor, 2014; North American Menopause Society, 2023)	Potentially harmful; safety unknown
Early menopause is worrying because	P2, P3, P6	Early and premature menopause also raise long-term risks to heart and bone (Svejme et al., 2012; Zhu et al., 2019)	Incomplete: the worry is real but misses the health risk

childbearing may be incomplete			
Herbal and English medicine used together	P6, P7	Safety depends on the herb and the drug; herbal products are poorly regulated and adverse effects are under-monitored (Ekor, 2014)	Unclear; the herbs used were not recorded in this study
Long-term risks rarely discussed	Only P7 mentioned osteoporosis	Bone loss after menopause raises the risk of osteoporosis and fracture, and women's earlier advantage in cardiovascular disease disappears (WHO, 2024)	Information gap; the main message missing from the channels

Note. Assessments are the authors' and are based on the sources cited; they describe beliefs and practices, not individual clinical care.

Table 4 shows that the indigenous framework agrees with biomedical knowledge on the points that matter most: women knew that menopause is a normal stage that ends childbearing. The risks cluster where information was missing, not where belief was wrong. Self-medication followed from failing to recognise symptoms, and the long-term risks to bone and heart were absent from the channels altogether. Health communication can therefore build on the existing framework rather than try to replace it.

Theoretical and Practical Implications

The study contributes three points to the use of the ethnography of communication in health communication. It locates the difference between communicative and institutional authority in the Participants and Norms components; it distinguishes silence as a shift of register from silence as a gap; and it shows an indigenous speech community carrying a biomedical label without the biomedical content behind it. Methodologically, an interview-based design gives access to women's accounts of speech events but not to the events themselves, and direct observation of menopause talk at markets and ceremonies would test whether these patterns hold in practice.

For practice, the findings support a participatory, culture-centred approach that works through existing community structures (Airhihenbuwa, 1995; Dutta, 2008; Freire, 1970; Melkote & Steeves, 2001; Servaes, 1999). The women in this study were active interpreters of their own experience, not passive recipients waiting to be reached. What they lacked was specific: information on recognizing symptoms, on early menopause and on long-term risk, delivered through the people and places they already trust.

Limitations

This study has several limitations. It draws on nine women in three communities in one state, so it describes patterns in these communities and cannot be generalized to rural Igbo women as a whole. Five women came from Umueze in Anam and two each from Nando and Achalla, and much of the richest material on *Ọpụpụ n'ama* came from a few accounts. Snowball referral tends to reach women who already know one another, and menopausal status was self-reported, not clinically confirmed. Interviews were fairly short, at 25 to 40 minutes, which limited probing. The findings rest on women's accounts of how menopause is discussed: the observation was brief, a market day and a church visit, and did not capture menopause talk as it happened, which limits how far the ethnography-of-communication analysis can go. Only women were interviewed, so the views of men, younger women, health workers and community leaders are missing. The first author's insider status and the presence of local research assistants may have shaped what participants said, and translation from Igbo to English may have lost some meaning despite the steps taken. Finally, the links between education, denomination and distance from village networks rest on a handful of cases and need testing in a larger sample.

RECOMMENDATIONS

The findings point to five recommendations for health educators, primary health care planners and leaders of women's organisations in south-eastern Nigeria.

1. Put menopause on the agenda of women's platforms that already meet, such as the CWO, the PFN, the August Meeting and church fellowships, and choose messengers for lived experience and closeness rather than title.

2. Use markets and ceremonies as entry points, since women there already interpret symptoms together. A message designed to travel through market conversation is likely to reach further than one that waits for a formal health talk.

3. Work with health workers, including nurses, community health workers and the traditional birth attendants (*ndị na-ana nwa*) who already combine herbal and Western care. Their task is to fill the gaps shown in Table 4: recognising symptoms, avoiding unsupervised sedatives, having early cessation of menstruation assessed, and understanding long-term risks to bone and heart.

4. Add local-language radio and phone-based voice messages as supplements, especially for women outside village networks. One participant named a radio station and another had no radio, and the study did not collect data on phone access, so these channels should be piloted before they are scaled up.

5. Tailor messages to the culture. Use the terms women use, such as *Ọpụpụ n'ama* and *nwanyị akazụgo*, keep the framing of menopause as maturity, and add accurate information on symptoms and long-term risks without dismissing indigenous explanations.

Future research should compare other Igbo-speaking and south-eastern Nigerian communities; include health workers, men and younger women; observe menopause-related speech events directly; test radio and mobile channels; and examine the patterns of education and denomination in a larger sample. Full verbatim transcription would preserve the exact wording women use to describe their bodies, which is where several of this study's richest findings lie.

CONCLUSION

This study began from a common portrait of rural menopausal women as a population that health communication overlooks: too old for reproductive health campaigns, too rural for mainstream media and too marginal for sustained research. The accounts of nine women in Nando, Achalla and Umueze in Anam suggest that the portrait is incomplete. These women lived inside several communication systems, among them family networks, markets, ceremonies and religious settings, which were active and trusted whether or not they carried menopause information.

The gap these accounts reveal lies less in channels than in content. The systems the women relied on had credible messengers, culturally fitting ways of discussing sensitive matters indirectly, and shared frameworks for interpreting bodily change. They lacked accurate information on recognising symptoms, on early menopause and on long-term risks to bone and heart. Health communication that works through these systems, rather than around them, has the better chance of supplying what is missing.

Data availability: Interview data are not publicly available because they could identify participants in small communities. De-identified excerpts may be requested from the corresponding author, subject to ethical approval.

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REFERENCES

1. Adekunle, A. O., Fawole, A. O., & Okunlola, M. A. (2000). Perceptions and attitudes of Nigerian women about the menopause. Journal of Obstetrics and Gynaecology, 20(5), 525–529. https://doi.org/10.1080/014436100434767
2. Airhihenbuwa, C. O. (1995). Health and culture: Beyond the Western paradigm. Sage.

3. AlSwayied, G., Frost, R., & Hamilton, F. L. (2024). Menopause knowledge, attitudes and experiences of women in Saudi Arabia: A qualitative study. BMC Women's Health, 24. https://doi.org/10.1186/s12905-024-03456-7
4. Amadiume, I. (1987). Male daughters, female husbands: Gender and sex in an African society. Zed Books.
5. Ansu-Kyeremeh, K. (Ed.). (2005). Indigenous communication in Africa: Concept, application and prospects (2nd ed.). Ghana Universities Press.
6. Basso, K. H. (1970). "To give up on words": Silence in Western Apache culture. Southwestern Journal of Anthropology, 26(3), 213–230.
7. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
8. Brown, J. K. (1982). Cross-cultural perspectives on middle-aged women. Current Anthropology, 23(2), 143–156.
9. Dutta, M. J. (2008). Communicating health: A culture-centered approach. Polity Press.
10. Ekor, M. (2014). The growing use of herbal medicines: Issues relating to adverse reactions and challenges in monitoring safety. Frontiers in Pharmacology, 4, Article 177. https://doi.org/10.3389/fphar.2013.00177
11. Eleje, G. U., Umeoranefo, I. C., Ezenkwele, E. P., Njoku, C. C., Rabiu, A., Chimbo, C., Ndukwe, C. O., Malachy, D. E., Eleje, L. I., Egwuatu, E. C., Oriji, S. O., Chikezie, R. U., Enweani-Nwokelo, I. B., Ezeora, N. C., Ikpeze, O. Z., Nweze, S. O., Osunkwo, A. C., Edeh, G. C., John, E. O., . . . MARIE Collaborative. (2026). Contextualising menopause in Nigeria: A qualitative analysis from the MARiE project. BJOG: An International Journal of Obstetrics and Gynaecology, 133(6), 1227–1240. https://doi.org/10.1111/1471-0528.70167
12. Ezeome, I. V., Ezugworie, J. O., & Nwankwo, T. O. (2019). Attitude of postmenopausal women toward the menopause and hormone treatment in Enugu, southeast Nigeria. International Journal of Women's Health and Reproduction Sciences, 7(3), 263–268. https://doi.org/10.15296/ijwhr.2019.44
13. Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. International Journal of Qualitative Methods, 5(1), 80–92. https://doi.org/10.1177/160940690600500107
14. Freire, P. (1970). Pedagogy of the oppressed (M. B. Ramos, Trans.). Herder and Herder.
15. Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: Interviews and focus groups. British Dental Journal, 204(6), 291–295. https://doi.org/10.1038/bdj.2008.192
16. Hajesmaeel-Gohari, S., Shafiei, E., Ghasemi, F., & Bahaadinbeigy, K. (2021). A study on women's health information needs in menopausal age. BMC Women's Health, 21(1), Article 434. https://doi.org/10.1186/s12905-021-01582-0
17. Hofnie-Hoëbes, K., Weightman, A., Shatona, M., & Kelson, M. (2018). Information sources consulted by women in African countries to manage menopausal symptoms: A systematic review and meta-analysis. Open Journal of Nursing, 8(5), 317–338. https://doi.org/10.4236/ojn.2018.85027
18. Hymes, D. (1962). The ethnography of speaking. In T. Gladwin & W. C. Sturtevant (Eds.), Anthropology and human behavior (pp. 13–53). Anthropological Society of Washington.
19. Hymes, D. (1974). Foundations in sociolinguistics: An ethnographic approach. University of Pennsylvania Press.
20. Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Sage.
21. Lock, M. (1993). Encounters with aging: Mythologies of menopause in Japan and North America. University of California Press.
22. Makuwa, G. N., Rikhotso, S. R., & Mulaudzi, F. M. (2015). The perceptions of African women regarding natural menopause in Mamelodi, Tshwane district. Curationis, 38(2), Article 1531. https://doi.org/10.4102/curationis.v38i2.1531
23. Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. Qualitative Health Research, 26(13), 1753–1760. https://doi.org/10.1177/1049732315617444
24. Melby, M. K., Lock, M., & Kaufert, P. (2005). Culture and symptom reporting at menopause. Human Reproduction Update, 11(5), 495–512. https://doi.org/10.1093/humupd/dmi018

25. Melkote, S. R., & Steeves, H. L. (2001). Communication for development in the Third World: Theory and practice for empowerment (2nd ed.). Sage.
26. Mengue Ngadena, Y. S., Ondoua Mbengono, L. J., Chuisseu Djamen, D. P., & Dzeufiet Djomeni, P. D. (2021). Menopausal management practices in sub-Saharan Africa: A cross-sectional study of Cameroonian women. International Journal on Integrated Education, 4(6), 358.
27. North American Menopause Society. (2023). The 2023 nonhormone therapy position statement of The North American Menopause Society. Menopause, 30(6), 573–590. https://doi.org/10.1097/GME.0000000000002200
28. Nsereka, B. G., & Adiele, K. (2013). Gauging the comparative effectiveness of trado-modern media in grassroots campaigns: The case of NOA mandate. New Media and Mass Communication, 13, 7–16.
29. Obaremi, O. D., & Olatokun, W. M. (2022). A survey of health information source use in rural communities identifies complex health literacy barriers. Health Information & Libraries Journal, 39(2). https://doi.org/10.1111/hir.12364
30. Rasweswe, M. M., & Mulaudzi, F. M. (2022). Indigenous knowledge, beliefs, practices and treatments of menopause among females of African descent. In F. M. Mulaudzi & R. T. Lebese (Eds.), Working with indigenous knowledge: Strategies for health professionals (pp. 127–141). AOSIS. https://doi.org/10.4102/aosis.2022.BK296
31. Saville-Troike, M. (1985). The place of silence in an integrated theory of communication. In D. Tannen & M. Saville-Troike (Eds.), Perspectives on silence (pp. 3–18). Ablex.
32. Saville-Troike, M. (2003). The ethnography of communication: An introduction (3rd ed.). Blackwell.
33. Servaes, J. (1999). Communication for development: One world, multiple cultures. Hampton Press.
34. Shaghaghi, A., Bhopal, R. S., & Sheikh, A. (2011). Approaches to recruiting "hard-to-reach" populations into research: A review of the literature. Health Promotion Perspectives, 1(2), 86–94. https://doi.org/10.5681/hpp.2011.009
35. Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. Education for Information, 22(2), 63–75. https://doi.org/10.3233/EFI-2004-22201
36. Soola, E. O. (Ed.). (2003). Communicating for development purposes. Kraft Books.
37. Svejme, O., Ahlborg, H. G., Nilsson, J.-Å., & Karlsson, M. K. (2012). Early menopause and risk of osteoporosis, fracture and mortality: A 34-year prospective observational study in 11,000 women. BJOG: An International Journal of Obstetrics and Gynaecology, 119(7), 810–816. https://doi.org/10.1111/j.1471-0528.2012.03324.x
38. Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. Qualitative Research, 4(2), 161–178. https://doi.org/10.1177/1468794104044430
39. Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care, 19(6), 349–357. https://doi.org/10.1093/intqhc/mzm042
40. Ugboajah, F. O. (1985). "Oramedia" in Africa. In F. O. Ugboajah (Ed.), Mass communication, culture and society in West Africa (pp. 165–176). Hans Zell.
41. Wathen, C. N., & Harris, R. M. (2007). "I try to take care of it myself": How rural women search for health information. Qualitative Health Research, 17(5), 639–651. https://doi.org/10.1177/1049732307301236
42. Wilson, D. (1987). Traditional systems of communication in modern African development: An analytical viewpoint. Africa Media Review, 1(2), 87–104.
43. World Health Organization. (2024, October 16). Menopause [Fact sheet]. https://www.who.int/news-room/fact-sheets/detail/menopause
44. Zhu, D., Chung, H.-F., Dobson, A. J., Pandeya, N., Giles, G. G., Bruinsma, F., Brunner, E. J., Kuh, D., Hardy, R., Avis, N. E., Gold, E. B., Derby, C. A., Matthews, K. A., Cade, J. E., Greenwood, D. C., Demakakos, P., Brown, D. E., Sievert, L. L., Anderson, D., . . . Mishra, G. D. (2019). Age at natural menopause and risk of incident cardiovascular disease: A pooled analysis of individual patient data. The Lancet Public Health, 4(11), e553–e564. https://doi.org/10.1016/S2468-2667(19)30155-0