



Menopausal symptoms and coping strategies: A community-based study in the Bamenda health district, Cameroon

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Abstract

Introduction: Menopause brings diverse physical, psychological, and emotional challenges, often leading women to seek for solutions for varied health conditions. In Cameroon, despite the increasing number of menopausal women, there is limited attention to the symptoms and coping strategies employed by these women. This study aims to assess symptoms and coping strategies among menopausal women in the Bamenda Health District.

Materials and methods: This was a community-based, descriptive cross-sectional study carried out for six months in the Bamenda Health District, Cameroon. We included menopausal women aged 45-60 years who gave their informed consent to participate in the study. Participants were selected using a convenience sampling technique. A pretested interviewer administered questionnaire was used to collect data on the sociodemographic characteristics, menopausal symptoms and coping strategies. Data were analysed using SPSS version 25.0.

Results: The three most common menopausal symptoms were hot flashes (89.3%), night sweats (83.1%), and sleep disturbances (71.3%). Physical and mental exhaustion (66.5%), and vaginal dryness (61.4%) were the most reported psychological and urogenital symptoms respectively. Most women (62.9%) sought medical care for symptom relief, while 54% used complementary and alternative therapies. Majority (50.7%) wore layered clothing to manage hot flashes, regulated room temperature (60.3%) to cope with night sweats, and engaged in physical activities (50.4%) to cope with mood swings. About 48.2% avoided sex to cope with vaginal dryness. In addition, 41.2% avoided caffeine before bed to cope with sleep disturbances, while 52.6% took short daytime naps to cope with fatigue. About 50.4% used over-the-counter pain relievers to cope with joint pains and 27.9% practiced relaxation techniques for emotional symptoms.

Conclusion: The most common symptoms were hot flashes, musculoskeletal pain and sleep disturbances. Non-pharmacology methods were often used as coping strategies.

Keywords: menopause, symptoms, coping strategies, Cameroon

Résumé

Symptômes de la ménopause et stratégies d'adaptation : une étude communautaire menée dans le district sanitaire de Bamenda, au Cameroun

Introduction: La ménopause entraîne divers défis physiques, psychologiques et émotionnels, poussant souvent les femmes à rechercher des solutions pour différents problèmes de santé. Au Cameroun, malgré le nombre croissant de femmes ménopausées, une attention limitée est accordée aux symptômes et aux stratégies d'adaptation utilisées par ces femmes. Cette étude vise à évaluer les symptômes et les stratégies d'adaptation chez les femmes ménopausées du district de santé de Bamenda.

Matérielles et méthodes: Il s'agissait d'une étude transversale descriptive, communautaire, menée pendant six mois dans le district de santé de Bamenda, Cameroun. Nous avons inclus des femmes ménopausées âgées de 45 à 60 ans ayant donné leur consentement éclairé pour participer à l'étude. Les participantes ont été sélectionnées par une technique d'échantillonnage de convenance. Un questionnaire prétesté, administré par un enquêteur, a été utilisé pour recueillir des données sur les caractéristiques sociodémographiques, les symptômes de la ménopause et les stratégies d'adaptation. Les données ont été analysées à l'aide du logiciel SPSS version 25.0.

Résultats: Les trois symptômes ménopausiques les plus fréquents étaient les bouffées de chaleur (89,3 %), les sueurs nocturnes (83,1 %) et les troubles du sommeil (71,3 %). L'épuisement physique et mental (66,5 %) et la sécheresse vaginale (61,4 %) étaient respectivement les symptômes psychologiques et urogénitaux les plus rapportés. La plupart des femmes (62,9 %) ont consulté un professionnel de santé pour soulager les symptômes, tandis que 54 % ont eu recours à des thérapies complémentaires et alternatives. La majorité portait des vêtements en couches (50,7 %) pour gérer les bouffées de chaleur, régulait la température ambiante (60,3 %) pour faire face aux sueurs nocturnes et pratiquait des activités physiques (50,4 %) pour gérer les sautes d'humeur. Environ 48,2 % ont évité les rapports sexuels pour faire face à la sécheresse vaginale. De plus, 41,2 % évitaient la caféine avant le coucher pour gérer les troubles du sommeil, tandis que 52,6 % faisaient de courtes siestes pendant la journée pour gérer la fatigue. Environ 50,4 % utilisaient des analgésiques en vente libre pour soulager les douleurs articulaires et 27,9 % pratiquaient des techniques de relaxation pour les symptômes émotionnels.

Conclusion: Les symptômes les plus fréquents étaient les bouffées de chaleur, les douleurs musculo-squelettiques et les troubles du sommeil. Des méthodes non pharmacologiques étaient souvent utilisées comme stratégies d'adaptation.

Mots clés: ménopause, symptômes, stratégies d'adaptation, Cameroun

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What is known on this topic

- Worldwide, menopausal symptoms have a negative impact on quality of life
- In Africa, the symptoms are relatively common but are often under-recognised.
- Coping strategies often used by African women are lifestyle adjustments and herbs.

What this study adds

- It provides locally relevant data on the most common symptoms in a community
- It highlights the traditional, social and lifestyle bases coping strategies
- It identifies gaps in healthcare access and guides appropriate interventions

1 | INTRODUCTION

Menopause is a natural biological process that marks the end of a woman's reproductive years. It signifies the cessation of ovarian function, leading to a decline in the production of key hormones like oestrogen and progesterone with permanent loss of menstruation. Natural menopause is deemed to have occurred after 12 consecutive months without menstruation for which there is no other obvious physiological or pathological cause and in the absence of any clinical intervention [1]. Because of the physical and emotional changes that result, this is a crucial and complicated time for women.

Menopause typically occurs between 45 and 55 years [2]. Reported mean ages of menopause in Africa, were 45 years in Somalia, [3], 49.1 years in Nigeria [17], and 47.4 years in Zambia [5]. With increasing life expectancy and relatively stable menopausal age, women are likely to spend half their lives in the postmenopausal period. Using age 50 as a proxy, it is estimated that by 2030, the world population of menopausal and postmenopausal women will increase to 1.2 billion, with 47 million new entrants annually [6].

Menopausal symptoms are generally grouped into physical symptoms (including vasomotor symptoms), psychological symptoms and urogenital symptoms [7]. They are usually triggered by declining oestrogen levels even before menopause is complete. Physical complaints include hot flashes, night sweats or chills, palpitations, fatigue, joint and muscle pain, loss of skin tone, sleep disturbances and headaches [8]. Psychological complaints include loss of confidence, mood swings, irritability, forgetfulness, poor concentration, anxiety and depressive symptoms [8,9]. Urogenital complaints often include vaginal dryness, itching, burning, and dyspareunia, loss of libido, recurrent urinary tract infections, and urinary incontinence [9]. The experience of these symptoms varies widely, influenced by lifestyle, race/ethnicity, socio-economic status, passive exposure to smoke, higher body mass index, premenstrual symptoms, perceived stress and age onset of menopause [10]. These symptoms can negatively influence the women's daily life activities and some of these women are not mindful of the changes brought

about by menopause.

To cope with these complaints, women adopt different strategies. These include empowerment through health education and self-management learning, lifestyle practices, support networks (family, friends, and community members), dietary practices, physical activity, hormone replacement therapy (HRT), non-hormonal therapy, and complementary and alternative medicine [7, 11-14]. African women often incorporate traditional diets, including soy products, sorghum-based meals, and leafy vegetables, which are believed to provide antioxidants and natural estrogens. These foods may help maintain healthy body weight, and alleviate symptoms such as hot flashes and night sweats [15, 16]. In addition, some African women turn to religious and spiritual practices, which provide emotional comfort and community support [15].

Despite these coping strategies, many women suffer from menopausal symptoms silently and are often unaware of where to seek help. While some women seek medical advice for managing menopausal symptoms, others resort to self-medication due to limited access to healthcare services. In Cameroon, a significant number of women reported self-treatment to manage symptoms, highlighting the need for improved healthcare access and education [17].

In the absence of a well-defined intervention strategy, coupled with the increasing number of menopausal women developing disabling symptoms necessitating medical attention, it is becoming necessary to rebuild our reproductive health policy including menopause management. However, few studies exist on menopause in most parts of sub-Saharan Africa and in Cameroon in particular. Identifying common symptoms, and coping strategies is essential to guide interventions and improve women's health outcomes. The objective of this study was therefore to determine the most common menopausal symptoms in a community setting in Cameroon and the coping strategies these women commonly use.

2 | MATERIALS AND METHODS

Study design and study setting

This was a community-based descriptive cross-sectional study conducted from January 1st to June

1st 2024 in the Bamenda Health District (BHD), one of the 21 health districts of the North West Region of Cameroon. The District is located in Bamenda, the regional capital of the North West Region and is administratively divided into 17 health areas. The BHD has an estimated population of 360,523 inhabitants and contains 36 health facilities, equally distributed between public (18) and private (18 private) institutions.

Study population and sampling

The study population was made of menopausal women residing in the Bamenda Health District during the study period. We included all women aged 45-60 years who reported the absence of menstruation for more than 12 consecutive months without medical treatment or surgical intervention. We excluded women diagnosed with or receiving treatment for any gynecological malignancy, as well as those undergoing treatment for chronic diseases with symptoms resembling menopause at the time of recruitment. Participants were selected using a convenience sampling technique. The minimum sample size calculated using the Lorentz formula was 272, based on a Z-value of 1.96 for a 95% confidence interval, and a prevalence (p) of vasomotor symptoms of 77% from a similar study done in

Study procedure

Ethical clearance was obtained from the Institutional Review Board of the Faculty of Health Sciences, The University of Bamenda and administrative authorizations were obtained from the Regional Delegation of Public Health and the Quarter heads of the communities in the BHD. Participants were approached individually in their households and after explaining the study objectives, purpose and procedure in Pidgin English, English or French as needed, written or verbal informed consent was obtained. Those who did not consent were excluded from the study and assured that there would be no consequences for not participating. All eligible participants underwent an interview with the use of a pretested data collection form in the English language.

Data collection

Data was collected on socio-demographic characteristics, menopausal symptoms and coping

strategies employed by these women. The socio-demographic characteristics included age, religion, education level, occupation and marital status. Age was dichotomised as 45-49 years and 50-60 years. Marital status was categorised as married or single (not currently in a marital union such as never married, widowed, divorced). The level of education was recorded as no formal education, primary, secondary or tertiary education. Occupation was categorized as employed (public and private), self-employed, and housewife.

Menopausal symptoms were classified into somatic, psychological and urogenital categories. Somatic symptoms included joint and muscular discomfort, hot flashes, sleep disturbances and heart discomfort or palpitations. Psychological symptoms included self-reported depression, anxiety, irritability, and physical and mental exhaustion (fatigue). Urogenital symptoms comprised of pain or burning sensation in the vulva, pain during urination, vaginal dryness and urinary incontinence or frequency.

Health-seeking behaviors were assessed to determine whether participants sought medical intervention, alternative or complementary therapies, or support and information from support groups, online forums, or social media. Factors that could influence the choice of management strategies were also examined, including cultural or traditional beliefs, personal research, recommendations from friends or family, and advice from healthcare professionals.

Coping strategies were defined as the methods women employed to manage menopausal symptoms. They could choose several options that applied for each symptom. Strategies addressing somatic symptoms included using fans or coolers, adjusting room temperature, wearing layered clothing, using breathable bedding, practicing relaxation techniques, engaging in gentle exercises, taking over-the-counter pain relievers, and maintaining a balanced diet. Additional measures involved avoiding caffeine and stimulants before bedtime, creating a relaxing bedtime routine, establishing a regular sleep schedule, taking short naps during the day, and using heat or cold therapy. Strategies targeting psychological and emotional symptoms included engaging in physical activity, practicing mindfulness or meditation, consulting

healthcare professionals, incorporating healthy lifestyle habits, practicing relaxation techniques, and seeking social support. Urogenital symptoms were managed through the use of hormonal creams or treatments, over-the-counter lubricants, or avoiding sexual activity when necessary.

Data analysis

The data were entered into the Statistical Package for Social Science (SPSS) version 26.0 for processing and analysis, and subsequently exported to an Excel spreadsheet. Descriptive statistics were used to assess the prevalence of menopausal symptoms and coping strategies. The data was summarized using frequencies and percentages.

Ethical considerations

Ethical clearance was obtained from the Institutional Review Board of the Faculty of Health Sciences of The University of Bamenda. (Project Identification number: 2024/0112H/UBa/IRB). Administrative authorizations were obtained from the Regional Delegation of Public Health for the North West Region and from the Quarter heads of the communities. Before administering the questionnaire, the study was explained to each participant in detail, and a written or verbal consent was obtained.

RESULT

Socio-demographic characteristics of the study participants

The mean age of the participants was 52.4 years (± 4.8). The majority of women were married ($n=207$, 76.1%), had primary education ($n=105$, 38.6%) as highest level of education and were self-employed ($n=185$, 68.0%) (Table I).

Menopausal symptoms among study participants.

The three most reported symptoms were hot flushes ($n= 243$, 89.3%), joint and muscular discomfort ($n= 226$, 83.1%) and insomnia ($n=194$, 71.3%). The most common somatic symptom was hot flushes ($n= 243$, 89.3%). The most common psychological symptom was physical and mental exhaustion ($n=181$, 66.5%). For urogenital symptoms, the majority of the women reported vaginal dryness ($n=167$, 61.4%) (Table II).

Coping strategies employed by study participants

Among the participants, 62.9% ($n=171$) sought medical care for the management of menopausal symptoms 54% ($n=147$) used alternative or complementary therapies, and 61% ($n=166$) sought support from support groups, online forums or social media. The choices of 36.8 % ($n=100$) of participants were influenced by recommendations from healthcare professionals (Table III).

Coping strategies employed by study participants

In terms of coping strategies, 50.7% ($n=138$,) wore layered clothing to cope with hot flushes, 60.3%, ($n=164$) adjusted room temperature to cope with night sweats, 50.4% ($n=138$) engaged in physical activity to manage mood swings, 48.2% ($n=131$) avoided sex to cope with vaginal dryness, and 41.2% ($n=112$) avoided caffeine and stimulants before bed to cope with sleep disturbances. About 52.6 %($n=143$) took short naps during the day to cope with fatigue, while 50.4% (137) used over-the-counter pain relievers to cope with joint pains. For emotional symptoms, 27.9% ($n=76$) practiced relaxation techniques. (Table IV).

Table I. Sociodemographic characteristics of study participants ($n = 272$)

Variable	Frequency(n)	Percentage (%)
Mean age (years)	52.4 (± 4.8).	
Age range (years)		
45 – 49	151	55.5
50 – 60	121	44.5
Marital status		
Single	65	23.9
Married	207	76.1
Level of Education		
No formal education	61	22.4
Primary	105	38.6
Secondary	58	21.3
Tertiary	48	17.6
Profession		
Employed	48	17.7
Self-employed	185	68.0
Housewife	39	14.3

Table II. Menopausal symptoms among study participants (n = 272)

Variable	Frequency(n)	Percentage
Somatic		
Hot flushes	24	89.
Joint and	3	3
Sleep	22	83.
Heart	6	1
Psychological		
Depression	16	59.
Anxiety	2	6
Irritability	16	60.
Physical and	4	3
Urogenital		
Pain or	10	39.
Pain when	7	3
Vaginal	94	34.
Urinary	16	6

Table III. Health seeking behaviours of study participants (n=272)

Characteristic	Frequency(n)	Percentage (%)
Sought medical intervention	171.0	62.9
Sought alternative or complementary therapies	147.0	54.0
Sought support or information from support groups , online forums or social media	166.0	61.0
Factors influencing the choice of management strategies		
Cultural or traditional beliefs	24.0	8.8
Personal research and information seeking	90.0	33.1
Recommendations from friends or family	58.0	21.3
Recommendations from healthcare professionals	100.0	36.8

Table IV. Coping strategies among study participants (n=272)

Characteristic	Frequency(n)	Percentage (%)
Coping strategies for hot flushes		
Using fans or coolers	103.0	37.9
Using relaxation techniques	31.0	11.4
Wearing layered clothing	138.0	50.7
Coping strategies for night sweats		
Adjusting room temperature	164.0	60.3
Using breathable bedding	74.0	27.2
Using relaxation techniques	34.0	12.5
Coping strategies for sleep disturbances		
Avoiding caffeine and stimulants before bed	112.0	41.2
Creating a relaxing bedtime routine	100.0	36.8
Establishing a regular sleep schedule	60.0	22.1
Coping strategies for mood swings		
Engaging in physical activity	138.0	50.7
Practicing mindfulness or meditation	40.0	14.7
Seeking social support	94.0	34.6
Coping strategies for fatigue		
Engaging in physical activity	52.0	19.1
Maintaining a balanced diet	71.0	26.1
Taking over-the-counter medications	6.0	2.2
Taking short naps during the day	143.0	52.6
Coping strategies for joint pain		
Engaging in gentle exercises	104.0	38.2
Taking over-the-counter pain relievers	137.0	50.4
Using heat or cold therapy	31.0	11.4
Coping strategies for emotional aspect of menopausal symptoms		
Consulting with a healthcare professional to explore options	64.0	23.5
Engaging in regular physical exercise	61.0	22.4
Incorporating healthy lifestyle habits	32.0	11.8
Practicing relaxation techniques	76.0	27.9
Seeking support from friends	39.0	14.3
Coping strategies for vaginal dryness		
Avoiding sex all together	131.0	48.2
Using hormonal creams or treatments	55.0	20.2
Using over-the-counter lubricants	86.0	31.6

4 | DISCUSSION

This study aimed to assess menopausal symptoms and coping strategies among menopausal women in the Bamenda Health District. The mean age of participants was 52.4 years (± 4.8). Most were married (76.1%), had primary education as their highest level of education (38.6%), and were self-employed (68.0%). The most common symptoms

were hot flushes (89.3%), joint and muscular discomfort (83.1%) and sleep disturbances (71.3%). Physical and mental exhaustion was the most frequent psychological symptom (66.5%), while vaginal dryness (61.4%) was the most reported urogenital symptom. About 62.9% of the women sought medical care, while 54% used alternative therapies. The most used coping strategies for the most frequent symptoms included wearing layered clothing for hot flushes, resorting to over-the-counter pain relievers for musculoskeletal pain, reduced caffeine and stimulants before bed for sleep disturbances, short naps for fatigue, and avoiding sex for vaginal dryness.

The pattern and severity of menopausal symptoms vary across ethnic groups. Asian women generally report fewer complaints compared to African American women who report more, particularly vasomotor symptoms the most [18]. In this study, the most common symptoms were hot flushes, joint and muscular discomfort and sleep disturbances consistent with findings from a study done in Cameroon [17]. Hot flushes was the most frequently reported symptom, which aligns with observations from other African countries. [9, 19, 20]. However, a study in Asia reported a lower prevalence of hot flusher [21], which could be attributed to factors such as regular consumption of phytoestrogen-rich foods, cultural perceptions of menopause as a natural life transition, and lifestyle factors including physical activity, body mass index, and smoking which can also influence the experience of menopausal symptoms [22]. Active, non-smoking women with a healthy body mass index generally report fewer or less severe vasomotor symptoms. This effect could be attributed to the increased subcutaneous adipose tissue in overweight and obese women may provide an insulating layer that blunts abdominal heat transfer, which reduces the body's ability to respond to changes in core temperature and the anti-estrogenic effects of tobacco smoking [22]. A global systematic review of 321 studies identified joint and muscular discomfort instead as the commonest symptom, followed by vasomotor symptoms, with the latter more common in low- and middle-income countries especially among black women [23]. Other studies found loss of libido to be predominant among a younger group of women [8]. This indicates that study design, sociocultural factors, stigma

surrounding sexual health or the occupational demands of different populations can influence the reporting of symptoms.

Menopause has been associated with musculo-skeletal conditions such as osteoporosis, osteoarthritis and sarcopenia (age-related muscle wasting) [24]. The frequency of joint and muscle pain/discomfort observed in this study (83.1%) is consistent with findings from other studies [4, 8, 25] and a systematic review confirmed it as the most common complaint globally [23]. Possible explanations of this findings include, physically demanding occupations without ergonomic support, and comorbidities such as osteoarthritis, obesity, and hypertension [9 , 25] . Sleep disturbances (71.3%) were also common in this study, consistent with findings from other studies, which reported these complaints as difficulties falling asleep, staying asleep and early morning awakening, and noted that these symptoms are often worsened by vasomotor symptoms, anxiety and depression [9].

The most common psychological symptom in this study was physical and mental exhaustion or fatigue (66.5%), comparable to other reports [8, 26]. Fatigue likely results from physical symptoms that contribute to daytime exhaustion, as well as hormone decline that affects energy metabolism compounded by the effects of depression and anxiety [26]. Anxiety (60.3%) was more prevalent than reported in a study in Ethiopia [9] but lower than the findings from a study in India [27]. Its occurrence is possibly linked to hormonal fluctuations and psychosocial stressors related to aging, health, and familial responsibilities [21]. The frequency of depression (59.6%) was consistent with findings from a study done in India [27], but higher than reported in a study conducted in Ethiopia [9]. This difference could be explained by variations in lifestyle and health behaviours, as well as socio-cultural and psychosocial factors including stress and social roles.

As concerns urogenital symptoms, vaginal dryness was the most common symptom, which is consistent with findings from other studies [28]. Estrogen decline leads to urogenital atrophy, low sexual drive, reduced lubrication, dyspareunia, decreased urethral closure pressure, and increased susceptibility to infections and incontinence [29]. Variations in frequency across studies reflect

underreporting due to cultural stigma. However, other factors such as health, marital status (older age or new partner), mental health, and smoking may have a greater impact on women's sexual functioning than menopause status [30]. Urinary complaints were least reported in this study as seen in other studies [8, 31], though another study reported a higher prevalence in hospital-based attendees, possibly due to increased reporting in clinical settings [19].

How women perceive and respond to these symptoms is strongly influenced by cultural, socioeconomic, and educational factors, which in turn shape their health-seeking behaviour. Historically, menopausal symptoms have been hugely under-treated and under-reported, with many women struggling to manage bothersome symptoms, which can significantly affect quality of life. Asian women often rely on herbal remedies and dietary changes, whereas Western women more frequently use pharmacologic interventions [32]. Pharmacologic options such as hormone replacement therapy (HRT), selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), are considered very effective to reduce hot flashes, night sweats, and reduce psychological symptoms [13]. HRT also reduces joint stiffness, and preserves bone density [33]. Complementary and alternative medicine (CAM) is widely used in settings where traditional or herbal medicine is culturally embedded, although evidence on efficacy varies [34], while lifestyle modifications are widely adopted by women with mild to moderate symptoms or those who prefer non-pharmacologic approaches. In this study, 62.9% sought medical care, while 54% used CAM, reflecting findings in other studies where cultural beliefs, unfriendly attitude of health workers, stigma, cost, and limited awareness discourage formal care [8, 20]. However, the specific medical care and CAM used by the participants was not determined in this study.

In this study, vasomotor symptoms (VMS) such as hot flashes and night sweats were managed by layered clothing, adjusting room temperature and avoiding caffeine. Similar coping strategies including cooling techniques (wearing light clothing, using fans, and maintaining a cool sleeping environment), sleep hygiene, avoidance of triggers, regular physical activity, weight management, taking milk

before bedtime have been reported in other studies [35, 36]. These findings contrast with studies from other regions where HRT, cognitive-behavioural therapy (CBT), non-hormonal methods (SSRIs or SNRIs) and mindfulness-based stress reduction and relaxation techniques such as deep breathing and yoga were frequently used and shown to be effective [13, 36, 37]. Complementary therapies such as herbal remedies (primrose oil, black cohosh, and phytoestrogen-rich supplements), massage, acupuncture, and relaxation techniques have been shown to provide additional relief [11, 34, 38].

For musculoskeletal pain, most women in this study relied on over-the-counter analgesics, while fewer engaged in regular exercise. Regular physical activity or exercise, adequate sleep hygiene, hot water therapy diets rich in calcium, vitamin D, have been associated with reduced risk of osteoporosis and musculoskeletal complaints [13, 14]. CAM therapies, massage, acupuncture, and relaxation techniques may provide relief [38]. HRT helps to reduce joint stiffness, and preserving bone density, while analgesics or non-steroidal anti-inflammatory drugs can be used as symptomatic treatments [13, 24, 33].

In this study, fatigue was commonly managed by daytime naps, while some maintained a balanced diet and engaged in physical activity. Studies have reported that, concerning psychological symptoms, physical activity and relaxation techniques improved mood, enhanced cognition and reduced anxiety [14]. Exercise when performed in a controlled and regular way, has beneficial effects on the vitality and mental health of menopausal women increasing their general quality of life [14, 39]. Adequate sleep, balanced nutrition, and avoidance of stimulants further helped to support emotional regulation and mental resilience, while social support greatly reduced stress, depression, and anxiety [35, 39]. Structured therapies such as CBT, mindfulness-based stress reduction, and counselling have proven to be effective to alleviate psychological symptoms among women in settings with access to these services [37].

Many women normalize urogenital symptoms as an inevitable part of aging and may not seek professional care, relying instead on self-management strategies that may be insufficient. In this study, many women avoided sex to cope with vaginal

dryness whereas sexual activity itself may help maintain vaginal elasticity and lubrication [30]. Other participants used lubricants and hormonal creams to manage vaginal dryness, which is consistent with findings from other studies which found other non-pharmacologic strategies such as hydration, perineal hygiene, and wearing breathable clothing [29, 40]. Local estrogen therapy remains an effective intervention, improving lubrication, dyspareunia, and sexual satisfaction with minimal systemic effects [40]. Selective estrogen receptor modulators (SERMs), such as ospemifene, CAMs, and pelvic floor therapy, provide alternatives [29, 40, 41], while psychosocial support is necessary to cope with sexual relationships and social interactions [42]. Pelvic floor exercises, bio-feedback, and bladder training are recommended to manage urinary incontinence, urgency, and frequency, improving control and reducing the risk of recurrent infections [43]. Cultural beliefs and social norms significantly influence the choice of these coping mechanisms highlighting the need for culturally sensitive counselling in clinical practice.

There are some limitations to this research. First, it was conducted in one Health District limiting the generalisability of the findings to the wider population of the Region. Second, while the study explored menopausal symptoms, and coping strategies, it did not comprehensively evaluate the various lifestyle changes, the use of medical interventions or specific complementary and alternative therapies. Additionally, data were self-reported introducing the possibility of recall bias and inaccuracies in symptom reporting. Lastly, the study design could cause a selection bias.

5 | CONCLUSION

This study highlights the significant prevalence of menopausal symptoms, particularly hot flashes, joint and muscular symptoms and mental and physical exhaustion among women in the Bamenda Health District. Commonly employed coping strategies included regulating room temperature, wearing layered clothing, and engaging in physical activity. These findings highlight the need for creation of menopausal clinics as an integral part of the reproductive health delivery system in the country, which will incorporate individualized

counselling and treatment options. 🌿

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Authors' contributions: DWP, DN were involved in the design of the study and drafted the protocol. DWP, DN, NEF, NDD analysed the data. DWP, DN, AFE drafted and finalized the manuscript for publication. AAA, KSO, NDD, TWA, JDS edited the manuscript. All authors contributed to the writing of the paper and approved the final version.

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