



Menopausal Health Perceptions and Practices Among Meitei Women in Urban Imphal

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Abstract: Menopause is commonly regarded as a biomedical transition. However, the experience itself is affected by social and cultural conditions as well. This paper studies menopausal health perceptions and practices among Meitei women aged 45 years and above in urban Imphal, Manipur. Guided by William C. Cockerham's Health Lifestyle Theory, it interprets menopausal awareness, symptom recognition and health-seeking behaviours through the interaction of life chances, life choices and habitus. A descriptive cross-sectional survey was conducted online with 200 digitally literate women using closed-ended items and open-ended questions, which were analysed thematically. The study finds that, although awareness of menopause was generally high, many respondents did not seek medical advice or use supplements, but that menopause-related agency was exercised within household and cultural relationships rather than independently of them. Menopause was widely regarded as a natural life transition, a view that appeared to support acceptance, but could still add to the normalisation of symptoms and limited care-seeking. Family influences, cultural expectations and access to health resources additionally shaped women's responses. The study applies Health Lifestyle Theory to an under-researched Northeastern Indian context, showing how gender and family relations influence health-related choices and opportunities while drawing attention to the need for culturally and gender-sensitive menopause communication and aid, such as, preference for clearer information like in Meiteilon (local language among Meitei), greater understanding from family members, opportunities for open discussion, and more sensitive support from healthcare institutions and workplaces.

Keywords: Menopause, Health Lifestyle Theory, Cockerham, Meitei Women, gendered health-behaviour, urban Manipur

1. Introduction

Menopause is often said to be medicalised, like many other female biological events. However, it is also often ignored in community health narratives, especially in the state of Manipur (in India's northeast), where this study is being carried out. Because of this contradiction, there is an implicit act of ignoring proper discussion due to hesitation and shame, which in turn deprives women themselves of receiving sufficient guidance. In this light, for this particular paper, the study is being focused on the state of Manipur in India by looking at Menopause from a sociological lens. To this end, two questions have been put up which are: 'Why do women choose to act or not act when experiencing menopausal changes?' and 'How does their lifestyle embedded in their social context shape their behaviour in relation to menopause?' The Meitei are said to form a major share of the indigenous population in the Indian state of Manipur, located in the northeast. Besides, they possess a wide range of beliefs that are traditional and practices in health (Devi & Singh, 2022). A comprehensive article examining the interaction of social and cultural aspects with contemporary medical services and knowledge, and their influence on attitudes towards menopause, seems to be lacking (Ngangbam, 2024). Meitei women experience difficulties in coping with their choices of economic self-reliance with influences from the patriarchal structure (Khundrakpam & Sarmah, 2023). And although they've made history in Ima Keithel markets and the Nupi Lan movements, patriarchal traditions still keep Meitei women from openly talking about reproductive health. In contrast, the biomedical perspective has sometimes depicted menopause as a condition caused by a lack of hormones, which necessitates



treatment, with Hormone Replacement Therapy being the most prominent example (Kelly, 2011). Meanings of menopause are also found between these extremes and are influenced by family stories, availability of healthcare, cultural norms, and the status of older women in society. From a sociological perspective, menopause is also shaped by class, race, and access to healthcare. Like how Samuel (2024) has noted, women from marginalised communities, especially Black and Asian backgrounds, often face systemic barriers that bar them from receiving sufficient menopausal care. This again has put more weight on the need to examine menopause not only biologically but also as a structural issue.

Here, this study aims to explore the health lifestyles of Meitei women aged 45 and above in Imphal city, Manipur, with a specific focus on menopausal experiences and responses. Anchored in William C. Cockerham's Health Lifestyle Theory, the study tries to understand how health behaviours are structured by both life chances and life choices. By examining this phenomenon through a sociological lens, the study might contribute to the growing literature on gendered health and cultural health practices. It helps unpack how Meitei women actually live through menopause, not just as biology, but woven right into their daily lifestyles. Menopause has been studied from the viewpoints of medicine and public health. But there has been very little focus on the way menopausal experiences are influenced by health lifestyles of Meitei women of Manipur. Until recently, studies on menopause were mostly concerned with symptoms, biomedical solutions, and health-seeking patterns. Even though many recent works of literature show culture and social context as factors that affect menopausal experiences, very few studies have treated menopause as a health lifestyle occurrence that results from the interplay of life chances, life choices, and habitus.

Although much writing on menopause has addressed symptoms, awareness, and medical care, less has addressed the issue as a sociological health lifestyle occurrence and treats menopause as primarily a biological transition with limited attention to how the social structure, cultural dispositions, family knowledge and individual agency constitute women's experiences of menopause. This paper addresses that gap with the help of Cockerham's Health Lifestyle Theory to look into menopause among urban Meitei women. Besides, women's experiences, mainly those from ethnic and indigenous communities of Northeast India, have been very rarely the subject of sociological and public-health dialogue. This paper attempts to examine the experiences of Meitei women residing in the city of Imphal, who, although somewhat digitally connected and living in an urban environment, still belong to a culture where menopause is considered 'normal', not necessarily requiring deliberate attention, and the conversation about menopause usually takes place only in family networks and very rarely in clinical or public spaces. By making use of Cockerham's Health Lifestyle Theory, this paper views menopausal knowledge, symptom reporting and healthcare seeking not as mere personal decisions.

Objectives: Building on Cockerham's Health Lifestyle Theory, the current research is set to address the limitation by investigating how menopause knowledge, health behaviours, and healthcare utilisation of Meitei women integrate into their complete socio-cultural life. To address this gap, the present study pursues two interrelated objectives:

- i) To illustrate menopausal awareness, symptom experiences, information sources, and health-related responses of digitally engaged urban Meitei women (45 years and older) in Imphal.
- ii) To examine the extent to which these responses are conditioned by life chances, life choices, and habitus through the lens of Cockerham's Health Lifestyle Theory.
- iii) To highlight the role of cultural and gender-sensitive menopause health communication in Manipur.

2. Literature Review

Over the last fifty years or so, there has been a considerable increase in the number of publications on menopause. While earlier ones were mainly concerned with the physiological aspects, the latest ones pay attention not only to



physiology but also to the psychological and social aspects of menopause and the conditions that affect women's experience & response to it. Almost changing focus from the symptom checklist to the quality-of-life instruments is one of three aspects of this expansion of the literature that are very relevant to this study (Hilditch et al., 1996). Three aspects of this extension are highly related to our study: firstly, the transition from symptom checklists to quality-of-life instruments; secondly, the anthropological comparison of the menopausal experience across cultures; and thirdly, the usage of sociological theories of health lifestyle to explain access, behaviour, and structural inequality. This article brings together the strands through William C. Cockerham's Health Lifestyle Theory. Anthropological point of view by suggesting 'local biologies' (introduced to explain how cultural and biological factors interact and mould women's experiences of menopause (Lock, 1998). These include dietary practices, genetic factors that affect symptomatology and health-seeking behaviour as a way to understand menopause as the interaction between biological processes and cultural contexts (Lock, 1998). Comparing menopausal experiences of Japanese and Western women, Lock found that in Japan, hot flashes were less bothersome and less frequently mentioned, which implied that cultural interpretation has a significant impact on the experience of the body. Along a similar line of thought, building on cultural argument, Melby et al. (2005) claimed that differentiation in culture cannot be separated from historical and generational factors. They presented the concept of cohort effect, saying that women of different generations, e.g., those who went through war or rapid social change, may experience menopause in different ways because of the differences in lifestyle, diet, and social expectation. Collectively, the works of Lock and Melby have pointed menopause research in the direction of investigating how social history and cultural narratives intersect with biological transitions.

Jones and team brought that cultural perspective to Indigenous Australian women and documented that not only modifiable lifestyle factors but also culturally held beliefs determine how women experience menopausal symptoms and how they decide to cope with them (Jones, 2012). The focus of the paper on health promotion and social support for Indigenous midlife women is a stepping stone for viewing menopause in structurally specific community contexts, a perspective that inspires the present research on Meitei women as a regional community (Jones, 2012).

Santoro and his team restate the importance of the body-related mechanisms at the centre of vasomotor symptoms, dyspareunia, and sleep issues, but they still put these issues next to the changing moods and depressive symptoms (Santoro, 2015). In fact, for this study, it supports the sociological focus by showing that the experiences of women in Meitei families are both physically felt and socially interpreted.

Ahlawat et al. Shifted focus towards social determinants and behavioural changes. They revealed that financial difficulties, lack of awareness, and the unreliability of the location of menopausal services are some of the reasons why women often decide not to undergo treatment (Ahlawat, 2016). Namazi et al. (2019) and Stanzel et al. (2019, 2020) also engaged in studies on the influence of social determinants and health literacy. Education, socio-economic status, and family support, according to Namazi and his team, are the major factors that mould women's experiences of menopause and reflect Cockerham's concentration on structural inequities. Research by Stanzel among the refugee and Vietnamese-born women in Australia brought out the aspects of migration stories, poor literacy, and cultural shyness in talking about reproductive health, which are the barriers to access to health care. These studies not only collaboratively broaden Cockerham's model by depicting how habitus, deeply embedded cultural predispositions towards health, can either facilitate or hinder women's engagement in health-seeking behaviours but also show the influence of migration on these behaviours. Working with rural and urban women in Lucknow, Gupta and colleagues uncovered a major disparity in healthcare availability and health-seeking behaviour, among other things (Gupta, 2022). Panmei's work with an indigenous community in Northeast India revealed that traditional repertoires could act as resources for women to deal with menopausal stress (Aduana Panmei et al., 2023). Both agree with the point that going back to time-honoured practice is hardly ever just a



matter of choice; it is an adjustment to what is physically accessible in the home, community, and medical environments.

Recent studies have shifted the discussion towards the present-day Indian situation. Bijapurkar restricts the scope to the menopause period and gives priority to early intervention via education and healthcare instructions as a way to enable women to build up their coping mechanisms (Bijapurkar, 2024). Cyriac and team expose the systematic ignoring of menopausal health and reemphasise the need for self-care, together with supportive networks, at the same time as Ahlawat's call for easily available health-augmenting programmes (Ahlawat et al., 2016; Cyriac et al., 2024). Babbar and colleagues, with the National Family Health Survey-5 data, show premature menopause as a problem faced by women aged 30-39, mostly those with less education and belonging to a lower socio-economic class (Babbar et al., 2024; Tripathi et al., 2023). In aggregate, these studies present an understanding of menopause in a particular way, i.e., in the Health Lifestyle Theory terms of health experience, socially shaped ageing care and everyday lifestyle practices (Aaron et al., 2002).

3. Theoretical Framework

This study uses William Cockerham's Health Lifestyle Theory as the analytical system (Cockerham, 2005; 2021a). Health Lifestyle Theory (HLT) is a sociological theory of health behaviour that aims to explain the clustering of health practices along the lines of social position, the protective pattern of some communities and the disproportionate risk of others, as well as how individual health choices are systematically limited/circumscribed by the social structure (Cockerham, 2005). Cockerham combines the sociology of status groups by Max Weber, the concept of habitus by Pierre Bourdieu, and structuration theory by Anthony Giddens into a single setup that considers health behaviour as a social product, not a mere individual preference. The main point of HLT is that these patterns of behaviour are not accidental: on the contrary, they are organised and grouped using social class, age, gender, race and ethnicity, kinship position, and the structure of available networks. According to the theory, clustering can be explained through three constructs: life chances, life choices, and habitus.

The first two terms were initially taken from Max Weber's sociology of status and class (Weber, 1978). Life chances refer to the structural factors that determine the scope of possibilities for an individual, like family income, availability of healthcare, education, exposure to health-related information, together with the extent of autonomy one has in everyday activities. Life choices indicate the ways in which individuals decide to behave within those environmental factors, such as deciding whether to see a doctor, whether to tell family about one's sickness, whether to follow a special diet, or to keep quiet about it. As Nettleton had remarked, health-related behaviours go beyond being simple individual choices of lifestyle to constituting socially and culturally patterned practices mirroring the distribution of resources and opportunities in a society (Nettleton, 1995). The main idea that Weber brought to Health-related Lifestyles Theory (HLT) is essentially this dialectical interaction: choices can only be made within the limitations that chances determine. Cockerham brings together the three Weber-Bourdieu elements in one model (Cockerham, 2005). Health practices emerge owing to the interplay between life opportunities and life decisions. Habitus acts as the intermediary, and the health lifestyles that reflect different social classes are formed throughout the life course. Cockerham points out two aspects that are very relevant to this research. Firstly, the direction of influence is not predetermined: in some situations, the structural conditions are so powerful that behaviours follow class almost exclusively, whereas, if the individuals' personal resources, family support system, or biomedical connections are very strong, the individual may have the upper hand (Cockerham, 2005). Secondly, health lifestyles are not fixed: they can be strengthened, changed, or weakened when one gets new input from one's social life, including the physical experience of menopause itself. There are three lines along which the fit between Health Lifestyle Theory and a sociological study of menopause in urban Manipur runs:

Firstly, the way menopause is experienced and understood is influenced by the individual's social and cultural environment. The symptoms vary among cultural and social situations and may even be described as not typical



of menopause in their culture. That means their doctors may diagnose them as having other health conditions. Some may not even reveal those symptoms to the doctors at all. Menopause as a social and cultural situation means that the health care professionals who mainly focus on checking menopausal symptoms or hormone replacement therapy (HRT) have the likelihood to overlook the social environment as one of the factors (Hampson & Hibbard, 1996). Health Lifestyle Theory, then again, highlights the reasons and the conditions under which women decide to report or not report their symptoms, thereby empirically opening the right question.

Secondly, urban Meitei households are here exposed to the influence of various health fields. Beliefs and practices of the family related to women's body issues keep them very much entangled. Even though the truth is that biomedicine has been introduced as an alternative to conventional healthcare, and health information through education is becoming more widely disseminated, the unequal access to such goods and services remains a problem. At the same time, traditional knowledge and practices of health are still very much a part of women's day-to-day decisions about their health. One of the health theories, that is, Health Lifestyle Theory, may be a great way for the study of how women manage and resolve these competing influences as health decisions are being made.

Thirdly, menopausal practice very rarely takes the form of a single, clear decision like calcium supplementation, Hormone Replacement Therapy uptake, gynaecological consultation, and kin disclosure. Rather, it is a resulting behaviour, in line with HLT's assertion that health lifestyles are long-lasting patterns of action.

4. Methodology

The study adopted a descriptive cross-sectional survey along with an exploratory qualitative component. Closed-ended and multiple-response questions described patterns in menopausal awareness, experiences, and health practices, while open-ended questions explored participants' beliefs, interpretations, and personal responses to menopause. Participants were digitally literate Meitei women aged 45 years and above residing in the urban areas of Imphal East and West districts, Manipur. For recruitment purposes, convenience and snowball samplings were utilised. A pragmatic recruitment goal targeting at least 200 participants was decided in view of the study's nature, the available channels and networks that are community-based and lastly the feasibility of collecting data online. Since the study relied heavily on convenience sampling and snowball sampling, the final sample was supposed to uncover characteristic tendencies or patterns among digitally active Meitei women instead of giving population-level figures. The Google Forms survey link was initially circulated through community and personal networks, and participants were encouraged to share it with other eligible women.

A self-administered structured questionnaire through Google Form served as the tool for data collection, which encompassed a variety of types of questions, i.e., multiple-response, open-ended, and closed-ended questions. The questionnaire was a comprehensive one dealing with topics like menopausal awareness, health and lifestyle practices, sources of health-related information, care preferences, traditional remedies, and personal experiences of menopause. Some of the questions were adopted from the Menopause-Specific Quality of Life Questionnaire (MENQOL) (Hilditch et al., 1996), together with the literature. The questionnaire was subjected to a small pilot study to check the clarity and cultural acceptability, and the required corrections were carried out before its final dissemination.

Health Lifestyle Theory of Cockerham provided guidance to formulate the paper and analyse the data. Life chances, life choices and habitus are concepts used to evaluate access to health information and care, individual health decisions, as well as culturally transmitted beliefs and practices (Cockerham, 2005). The operationalisation of these concepts is presented in the table that follows. To operationalise Cockerham's Health Lifestyle Theory, three aspects- life chances, life choices, and habitus- were used to structure the questions. These aspects helped shape the questions on the availability of information and healthcare, personal health behaviours, and culturally transmitted patterns related to menopause.

Table 1: Operationalisation Table based on HLT

Cockerham's Concept	Operational Dimension	Questions/Items	Type of Data	Analytical Use
Life Chances	Menopausal awareness and health literacy	"Are you aware of menopausal syndromes?"; "How would you rate your knowledge about menopause?"	Closed-ended	Measures the level of awareness or knowledge.
Life Chances	Access to Information	"Where do you usually get information about health and menopause?"	Multiple responses	Figure out who the source of knowledge is - it can be doctors, family elders, media, books, social media, or the community.
Life Chances	Structural Constraints	"Do your daily responsibilities affect how much attention you can give to your own health?"	Closed-ended	Captures that household, work, and caregiving duties are limits to self-care.
Life Chances	Healthcare/supplement access	"Have you ever avoided seeking medical help or buying medicine/supplements? If yes, why?"	Closed-ended and Open-ended	Notes the cost, time, distance, lack of awareness, and perceived non-seriousness as obstacles.
Life Choices	Self-care agency	"Do you actively take steps to manage your health?" "Do/did you take a calcium supplement?"	Closed-ended	Indicates whether women knowingly get involved in managing their food, rest, exercise, and supplementation. Indicates preventive or corrective biomedical self-care.
Life Choices	Decision-making during discomfort	"When you experience discomfort or symptoms, do you decide how to handle it yourself?"	Multiple responses	Shows whether women decide on their own, depend on family, or consult doctors for advice.
Life Choices	Medical action	"Have you consulted a doctor for menopause-related concerns?"	Closed-ended	Indicates formal healthcare-seeking behaviour.
Life Choices	Remedy use	"What specific traditional remedies do/did you follow for your menopausal symptoms?"	Open-ended	Describe effective self-management methods like warm drinks, yoga, ginger tea, a hot water bag, changing diet, and local remedies.



Habitus	Cultural openness/silence	“Do you feel it is appropriate to talk openly about menopause and health issues within your family or community?”	Closed-ended	Indicates the patterns of modesty, privacy, selective openness, and silence.
Habitus	Meaning of Menopause	“How do you view menopause?”	Closed-ended	Captures whether menopause is framed positively, negatively, neutrally, or as a natural life phase.
Habitus	Gendered meaning and social expectation	“Is there anything about women’s menopausal health or lifestyle that you wish more people understood?”	Open-ended	It gives qualitative insights into aspects like endurance, support, understanding of family, awareness of the public, and emotional alterations.

Quantitative results were processed by frequencies and percentages in Google Sheets. Open-ended responses underwent thematic analysis through repeated reading, generation of initial codes, grouping of associated codes, theme development and interpretation. Qualitative responses were employed to provide insights into the quantitative findings. Cockerham's theoretical constructs were later used to interpret the ways that influence menopausal health behaviour.

Participation was voluntary. The aim of the research was explained to the participants, and the questionnaire was explained to them before they completed it. All responses were confidential, and no identifiers were reported. Participants were free to withdraw from taking part. The responses were used solely for academic purposes. Convenience and snowball sampling could have introduced selection bias, as participants recruited through common networks were likely to have similar levels of literacy, education and internet access. Women without internet access and those living in rural or remote areas were not represented. The findings should thus be interpreted as indicative patterns among digitally engaged urban Meitei women rather than representative of the wider population.

5. Findings

In total, there were 200 married Meitei women who were 45 years old and older and living in urban Imphal. The sample characteristics are shown by age distribution and menopausal status.

A) Among digitally-engaged urban respondents (n=200), 79% reported awareness of menopausal syndromes (Table 2). This suggests the urban and educational profile of the sample, where the 21% who have reported no awareness highlights that digital literacy does not automatically translate into health literacy, in this case, menopausal health literacy.

Table 2: Awareness and Perceptions of Menopausal Symptoms

Awareness of Menopausal Syndromes	Percentages
Yes	79%
No	21%

(B) Menopausal Status and Symptom Profile:

Table 3. Menopausal Status

Phase	Percentage
Perimenopausal	12.5%
Premenopausal	9.5%
Post-menopausal	78%

This distribution suggests that the study is primarily based on women who have already passed through the menopausal transition and are therefore able to reflect on their symptoms, health practices, and care-seeking behaviour from lived experience. They also revealed habitus, particularly in the normalisation of menopause as a natural process, the tendency to endure discomfort, and the reliance on inherited household or elder-guided practices. Meanwhile, the smaller groups of perimenopausal and premenopausal respondents point to the anticipatory dimension of menopausal health lifestyle, where women begin to understand, prepare for, or respond to bodily changes before menopause is fully reached. Thus, the table helps frame menopause not as a single biological event but as a gradual health lifestyle process involving anticipation, experience, adjustment, and retrospective interpretation.

Table 4: Major symptoms experienced

Symptoms Experienced	Percentage
Tiredness	46%
Hot flashes	37.5%
Night sweats	32%
Joint pain	30%

The remaining symptoms include depression, brain fog, leg swelling, muscle pain, heavy bleeding, chest pain, and back pain. Here, after following the Health Lifestyle Theory, active symptom reporting and supplement use will fall under life choice, which reflects personal agency in managing health, though these are also shaped by life chances (availability of supplements, affordability, access to medical advice). The higher relative reporting of tiredness in comparison with hot flashes could be an indication that the subjects conveyed menopausal discomfort in the form of general body fatigue rather than to be exact identified vasomotor symptoms.

C) Reasons for Avoiding Medical Help or Buying Supplements:

- **Financial constraints:** “Money problems.” “Cannot afford to buy medicine often.”
- **Indifference/Neutral stance:** “I think it is natural.” “No need for a doctor.”
- **Cultural restraint:** “Do not feel comfortable talking about it.”



25.9% have been found to be avoiding supplements, suggesting that life chances constrain agency, which is consistent with Cockerham's model. Avoidance also reflects **habitus**, i.e., the internalised habits and norms, here in this case, directing a person to endure discomfort by deflecting it to be natural and something that should be endured with no complaint. And **life chances**, i.e., the structural barriers such as the cost of consultancy or medicines themselves and access to health experts.

D) Sources of Health and Menopause Information:

Table 5. Primary Information Sources for Menopausal Health

Source	Percentage
Family members/relatives	82%
Doctors and Healthcare providers	55.5%
Elders' advice	43.5%
Television/Social-Media/Radio	40.0%

Participants were allowed to choose multiple sources of information. Even this urban, digitally connected group mainly relied on their family and their older people for details about the menopause. Medical and media sources were less commonly consulted. Health Lifestyle Theory would say that the family is a crucial setting in which women acquire their understanding of health-related matters and make their choices about health care consultations, use of medicines, home remedies or reliance on these. Because of this, it is through these very networks of family and friends that people come to get their informal sources of knowledge, though the information may not always be verified and the consequence for seeking medical help when symptoms become a concern could be delayed if they consider the menopause as simply a normal part of getting older.

E) Traditional Remedies They Followed:

- **Food-based practices:** "Simple and bland foods." "Simple home-cooked food, seasonal greens." "Avoiding cold foods, spicy foods and certain dishes like Uti thongba (a traditional vegetarian dish) as my mother did or my grandmother advised"
- **Exercise/physical activities:** "Sufficient physical movements." "Walking." "No tight-fitting clothes around the waist".

These simple traditional routines they have acquired would comprise the **habitus**, and if these are practised by them consciously in life, they would also fall within **life choices** because the choice and decision to perform the practices is within their options available to them and also within their capacity.

F) Views on Menopause:

- **Positive acceptance:** "It is just a part of life's process."
- **Neutral:** "Neither good nor bad, just natural."
- **Negative:** "more bodily and hormonal issues"



The majority of them viewed menopause neutrally/positively as "natural," though qualitative data revealed endurance habitus masking challenges. Views expressing negative outcomes, for example, "increased issues with the body and hormones," were rare. But a few responses brought out a contrast between, on the one hand, embracing menopause as a natural phase and, on the other hand, desiring more attention, dialogue and institutional assistance as socially acknowledged things.

G) Qualitative Themes - Themes from Women's Perspectives on Menopausal Health

Three Qualitative themes emerged after analysing the open-ended questions.

Theme 1 - Menopause as a natural but vital transitional phase: For most participants, menopause was considered a normal biological function rather than a disease, though with awareness and care. Some physical and emotional changes were acknowledged but were regarded as a part of ageing rather than a problem that had to be fixed. Menopause, as described by one woman, was just a biological transition, not a disease. Another participant thought of it as "a major milestone in a woman's life." These comments indicate that menopause was, to the participants, a natural transition to which women should be given more information, support and assistance. So, what the respondents told presents an alternative notion of menopause as solely an illness in which a biomedical view is the main perspective, and at the same time, they do not adopt the view that menopause is nothing but an unproblematic event which does not pose any health risks. This reflects the habitus that directs women to interpret menopause and the bodily changes thereafter as natural because they have inherited certain cultural beliefs from the older generations and through everyday learning from family about women's ageing.

Theme 2 - Importance of preventive health and lifestyle practices: Respondents emphasised diet, supplementation, exercise, and routine check-ups as protective measures. Representative quotes: "Start taking care of health even before menopause begins. Check-ups, especially for bone density, are important," and "Simple and good lifestyle habits, such as physical activity with balanced diets, can make the change easier." Respondents recognised that women could make certain choices to protect their health, such as improving diet, exercising, taking supplements, and undergoing check-ups. However, these choices are also connected to their life chances, since access to medical advice, affordability of supplements, time for exercise, and awareness of preventive care are not equally available to all women. Thus, this theme shows that preventive menopausal health is not simply a matter of individual responsibility. It is determined by the interaction between women's personal decisions and the social conditions that make those decisions possible.

Theme 3 - Concerns emotional, social, and structural support needs: Those who responded felt that emotional and workplace sensitivity are, in fact, essential besides medical treatments. Representative quotes were: "Menopause is not simply a physical occurrence; it is also a psychological and social change." "We want our workplaces and families to show less prejudice in them." The more general issue was revealed through the comment: "If more knowledge was around then, maybe I would have looked after myself more", which demonstrated both a retrospectively expressed regret and a wish for future empowerment. Such an issue explores that actually life chances are central to the formation of health behaviours in women during menopause. Support for women from emotional and interpersonal points of view, such as family understanding, flexibility in the workplace, and access to accurate information, is more than a personal matter. Rather, these are social factors that impact women's ability to make healthy decisions. Although women might be interested in seeking care, rest, exercise or adopting preventive measures, this mainly depends on whether or not their family, workplace, and wider social environment allow them the support to do so. Therefore, the theme says that menopausal health practices should not be seen merely as the result of one's knowledge or awareness, but also as a reflection of the social circumstances women are subjected to in both their private and work spheres of life.



6. Discussion

The findings are interpreted here by using Cockerham's Health Lifestyle Theory. In this theory, health behaviours are outcomes of life chances (for example, structural conditions like education, social class, and access to health facilities), life choices (the exercise of agency within those conditions), and habitus (deeply ingrained cultural predispositions). When the three ideas are combined instead of being considered individually, they highlight the main contradiction of the data: the obvious presence of personal agency at the same time as the unchanging structural constraint.

6.1 Life Chances: Urban Access Without Equitable Uptake:

Being near healthcare centres in Imphal didn't ensure getting menopausal care for everyone. Although 79% of participants said they knew about menopausal symptoms, 25.9% rejected supplements or doctors, explaining lack of money ("money problems, " "cannot afford to buy medicine often") as the biggest reason. Besides that, even though 55.5% indicated doctors as their main source of information, the family (82%) and elders (43.5%) were still the most trusted sources - this supports Cockerham's thesis that structural inequities, even in cities, impact health lifestyles, resulting in unequal access to awareness and care. Digital engagement also does not individualise menopausal health practices. Among the participating Meitei women, digital access or information coexisted with family advice, biomedical care or inherited practices. The findings also broaden understanding of menopause as a relational and socially situated health experience.

6.2 Life Choices: Agency Within Structural Boundaries:

Personal agency was a main focus of some of the data. For example, 55.5% of the respondents depended on their doctors, 42.5% stated that they were taking calcium at present, and some qualitative answers mentioned personal strategies like yoga, ginger tea, meditation, and consulting at the right time. Still, lessened agency was a consequence. For instance, the very act of avoiding or postponing care is a 'decision', but this is a decision that is influenced by one's financial situation, cultural norms, continued reliance on family members and elders, gendered and intergenerational relationships and the understanding that menopause is natural, and so it does not call for any interventions. The household-responsibility trade-off shows how life decisions are compromises rather than totally free-standing decisions. These findings align well with Cockerham's (2005) statement that choices are made in structural conditions rather than against them.

6.3 Habitus: Endurance, Selflessness, and Inherited Routines:

Habitus was the most prominent aspect that we could observe clearly and directly from women's words. One out of four women (26%) mentioned that even though she would have been able to get medical help, she still deliberately avoids this and accepts the physical symptoms. 97% of women considered menopause a 'natural' process. This way justifies silence about it, and the household-responsibility trade-off showed that the women had an internalised selflessness ethic, which is, in a sense, a mirrored pattern of what Oinam Sareeta Devi has found with Meitei women who suffer in silence while being the main health managers of their families.

The endurance habitus is strengthened by what Prakash Khundrakpam described as 'touheidaba', e.g. Meitei women commit daily practices that are influenced by selective mystical prohibitions or behavioural commandments. It is not just a matter of choice that they follow food restrictions, use traditional medicines, and heed the advice of elders; rather, these are the very ways of their generation through which they continuously demonstrate the inherited disposition. Even those respondents from urban areas who were digitally engaged and whose knowledge of menopause was very high frequently gave priority to family obligations rather than self-care, which means that knowledge acquisition by itself does not change the gendered habitus that is deeply rooted. And, menopause communication would not be sufficient to rely only on clinic or media-based distribution. Family members and relatives have been found to play the main role of knowledge source, and since many women learned



about menopause via guidance by elders and home-based knowledge, communicating menopausal health needs to utilise the cultural spaces while still being scientifically appropriate, where they already turn to for advice. At the same time, it has also been found that family-based knowledge may be the cause of normalising the endurance and delaying medical intervention when symptoms are being perceived as natural by treating them as such.

6.4 The Connection of the Three Dimensions:

The evidence indicates that rather than the three dimensions functioning one after the other, they are combined at each behavioural point. Taking calcium consumption, for instance, demonstrates personal agency (a life choice). Still, the actual calcium intake can be limited due to costs (a life chance), and it is internally normalised through family dietary patterns (a habitus). The stated reasons for not seeking medical help because of cultural reasons ("do not feel comfortable talking about it") would be interpreted as a habitus that masks a life chance that meets cultural responsiveness - or the lack of culturally sensitive services. Like that, even those respondents who stated that they were highly aware still put their own health at the bottom of the list of household responsibilities. This is a situation where life chances, choices, and the gendered habitus come together.

This reading is in line with Nettleton's fundamental insight that "health-related behaviours are not simply individual lifestyle choices but socially and culturally structured practices that express the unequal distribution of resources and opportunities in society" (Nettleton, 1995). Inspired by Mills's sociological imagination, the repeated patterns throughout the sample indicate that menopause, from the Meitei perspective, is more than an individual's biological change but a combined gendered experience that is influenced by habitus and life chances.

6.5 Implications

What has been found in this study has a double implication. Firstly, from a policy angle, just sending out general public health materials on menopause is not the right approach when talking about the Meitei context; interventions should be through the very kinship networks with which women are already familiar and trust, that is, family and elder pathways as means for menopause literacy. Secondly, from a theoretical standpoint, the evidence supports the usefulness of a cross-cultural application of Cockerham's structure but warns that the balance of life chances, choices, and habitus will be different in indigenous, modernising communities.

7. Conclusion

This research aimed to discover how the urban Meitei women of Imphal recognise, live, and handle menopause amidst the gender-based family commitments, cultural silence, and unequal availability of biomedical care. Using quantitative self-reports and qualitative voice, the study identified three intersecting realities: a high level of awareness with selective avoidance; a normal cultural depiction of menopause as 'natural', which then again makes the silence around it even more normal; and describing menopause as 'natural' served two different purposes. Firstly, it lessened the fright and made women experience the physical changes of the body as something they could live with. Secondly, it may have averted seeking medical advice, and it made bearing symptoms seem normal. And an internalised endurance ethic in which women's health is constantly sacrificed to the needs of households, workplaces, and kinship networks. In short, the study findings indicate that menopause is a social as well as biological event for urban Meitei women, which is affected mainly by the cultural orientation, role expectations of women and the gendered and socio-cultural restrictions.

7.1 Contribution and Possible Prospective Trajectory of the Study:

The study adds to the literature in that it uses Health Lifestyle Theory in the culturally unique environment of Meitei women in Northeast India, illustrating why gender and family relations influence health-related decisions and opportunities. Utilising quantitative findings complemented by qualitative ones, the study depicts menopause as less an individual matter of coping with discomfort and more an area in which family bonds, norms and roles as culturally defined, and the power-sharing dynamics in decision-making are all actively involved. So, the results



link how women individually perceive the situation with various social conditions, which in turn could either limit or facilitate their access to better life conditions through proper health care practices.

In the future, it would be helpful to locate a longitudinal study to record how knowledge, faiths, and health behaviour on menopause change as women transition from menopause to post-menopause, and how the habitus formed in middle life reshapes itself in older age. Besides, the research that is directed at interventions is necessary to find out if menopause literacy programs conducted through family and elder networks, which are the most authoritative sources of information identified in this study, result in greater engagement and better outputs compared to clinic-centric approaches that ignore kinship structures. Besides, initial research may also be useful here to see how digital platforms change, rather than eliminate, the traditional Meitei patterns of silence and self-care. The study, however, has limitations that warrant acknowledgement. Three limitations could be mentioned here. First of all, the sample of respondents was convenience-based, and in reality, they were from the urban part of Imphal, which limits us from extrapolating to the situation in rural Manipur and other parts of the Northeastern Indian region. Secondly, the online questionnaire method could have left out the elderly women who have limited opportunities to use digital devices. Finally, as it was a cross-sectional study, we could not establish a cause-and-effect relationship from it. The qualitative data, obtained from open-ended prompts, are naturally less in-depth than interview-based data. Regardless, the study offers empirical and theoretical contributions to the sociology of menopause in indigenous Northeast Indian contexts.

To conclude, this research sheds light on a daily gendered negotiation - the quiet, frequently unnoticed work of women silently enduring menopause while at the same time managing households, workplaces and even extended families. It further contends that only with a sociological perspective can we properly grasp the reality of menopause. By giving women the floor to tell their stories, the research reveals that menopause is, for Meitei urban women, simultaneously a physical change, a duty in the family, and a culturally defined role, i.e., a relational and socially situated health experience, which must be recognised if we want to move towards a menopausal discourse, policy and care that really listens, instead of prescribing, to the women whose lives these intends to support, such as, as the participants mentioned, preference for clearer information like in Meteilon (local language among the Meitei), greater understanding from family members, opportunities for open discussion, and counselling by trained female health workers or doctors.

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