



ORIGINAL RESEARCH ARTICLE

Perceptions of Physical Activity after Menopause among Bahraini Menopausal Women

Anastasia Athanasiou*

Consultant Orthopedics, Evexia Day Surgery, Bahrain



*Corresponding author: Anastasia Athanasiou, Consultant Orthopedics, Evexia Day Surgery, Bahrain

Abstract

Regular physical activity is a key non-pharmacological strategy for alleviating menopausal symptoms and reducing the risk of chronic disease in later life. Despite these benefits, many Bahraini postmenopausal women remain insufficiently active. Understanding how their experiences and motivation are shaped by family, community, and healthcare contexts is essential for guiding culturally appropriate interventions. This study examined how Bahraini postmenopausal women aged 50 years and above perceive and experience physical activity, explored its perceived relationship to menopausal symptoms, and assessed how familial, community, and healthcare influences shape motivation and engagement. Qualitative narrative design was employed. Twenty-five Bahraini postmenopausal women (50 years and above; mean = 66.4) were purposively recruited through the three accredited healthcare facilities in Bahrain. Data were collected through short written narratives and 30-45-minute semi-structured interviews conducted in Arabic or English. Interviews were audio-recorded, transcribed verbatim, translated where necessary, and analyzed using Braun and Clarke's reflexive thematic approach. Trustworthiness was enhanced through member-checking, peer debriefing, reflexive journaling, and maintenance of an audit trail. Five overarching themes emerged [1] holistic perceptions of physical activity as integral to daily routines, religious practices, and management of menopausal symptoms [2] multi-level barriers including health conditions, sociocultural norms, and environmental constraints [3] motivators such as familial support, health awareness, and faith-based purpose [4] adaptive strategies and self-efficacy and [5] Contextual Influences, including home-based routines, community engagement, and guidance from healthcare providers. These themes aligned with key constructs of the Health Belief Model. The findings underscore the need for culturally tailored, women-only, and climate-appropriate physical-activity initiatives that actively involve families, community networks, and healthcare professionals to promote and sustain participation among older Bahraini women.

Keywords

Menopause, Physical activity, Qualitative research, Bahrain, Health belief model, Healthcare providers

Introduction

Every woman experiences the menopause, a phase in which they are no longer able to conceive and experience permanent cessation of menstruation as a result of ovarian follicular activity. Menopause is not viewed as a disease or issue; rather, it is a normal aspect of aging for women, usually occurring between the ages of 45 and 55. Studies show that as the world's population ages, more women are transitioning [1]. More than 67,000 Bahraini women over 50 are going through or have already gone through menopause in Bahrain. They frequently complain of symptoms like exhaustion, muscle loss, sleeplessness, mood swings, and cognitive abnormalities, all of which can seriously lower their quality of life [2]. Women typically suffer from hormonal imbalances that lead to fast weight gain or loss, hair thinning, vitamin deficiencies, facial hair growth, or, in extreme cases, worsening conditions that require ovarian removal [3]. According to recent research, physical activity can help reduce menopausal symptoms and promote a long-term healthy lifestyle without the need for medication. Exercise has been shown in previous research to enhance personal well-being and reduce menopausal symptoms. These assertions are supported by more recent research, which shows that regular exercise lowers the risk of chronic diseases like osteoporosis, sarcopenia, cardiovascular disease, and obesity in addition to improving vasomotor

and psychological symptoms [4]. As an example, a systematic review conducted by Thomas and Daley (2020) found that physical exercise interventions enhanced postmenopausal women's mental health, vasomotor symptoms, and general quality of life [5]. In a similar vein, highlighted that integrating community engagement tactics with exercise promotion improves adherence and offers extra psychological advantages [6].

Physical activity has preventive benefits that go beyond reducing symptoms. Frequent exercise has been associated with lower blood pressure, cholesterol levels, body weight, and oxidative stress, which lowers the risk of non-communicable diseases, which are more common in the postmenopausal years [7,8]. In addition, recent randomized controlled trials and extensive longitudinal investigations have demonstrated that physically active women have superior musculoskeletal health outcomes and a reduced incidence of cardiovascular events than their sedentary counterparts [9-11].

Despite this data, midlife and older women's physical activity levels are still below ideal, especially in the Middle East [12]. Low participation rates in Bahrain and the larger Gulf region may be caused by sociocultural norms, family obligations, lack of access to women-only fitness centers, and a lack of medical advice. This emphasizes how urgently culturally aware health promotion programs that enable women to integrate physical exercise into their daily lives are needed.

When combined, these results demonstrate that exercise is an effective and affordable way to reduce menopausal symptoms and encourage healthy aging. Qualitative, context-specific studies examining Bahraini women's perceptions of physical activity during menopause and the factors that facilitate or impede their participation are still lacking, nevertheless. Designing evidence-based and culturally relevant health interventions requires an understanding of these lived experiences [13].

Knowledge gap in literature

Even though a lot of research has shown how beneficial exercise is for easing menopausal symptoms and lowering the risk of chronic illnesses, the majority of this research is from high-income, Western environments [14]. Despite being instructive, these results could not accurately reflect the sociocultural reality faced by Middle Eastern women. Specifically, in the Gulf region, women's capacity to participate in regular physical activity is frequently constrained by cultural norms, family expectations, and the scarcity of facilities suitable for their gender [15]. The research on menopause and exercise in Bahrain is still limited and dispersed. Women's health after midlife has received very little attention in the nation's existing research, which has mostly concentrated on reproductive health,

fertility, and maternity outcomes [16]. Insufficient is known about Bahraini women's attitudes toward physical activity beyond menopause, the obstacles they face, and how their families, communities, and healthcare professionals influence their behavior.

Additionally, there is less evidence of the Health Belief Model's (HBM) application in analyzing physical activity habits among postmenopausal women in Bahrain, despite the fact that it has been widely used to research health behaviors in a variety of populations. This is a significant theoretical and practical gap because using the HBM could provide a deeper understanding of how women's exercise decisions are influenced by perceived risks, benefits, obstacles, and cues to action in this particular sociocultural setting [17].

Eliminating this gap is essential to developing culturally aware treatments that encourage sustainable physical activity among Bahraini women after menopause by creating supportive surroundings and increasing knowledge.

Theoretical framework

The Health Belief Model (HBM), one of the most popular theoretical frameworks for comprehending behaviors related to health, serves as the foundation for this investigation. The foundation of HBM is the notion that people's perceptions of risk, benefits, obstacles, and their confidence in their ability to overcome them all influence their health-related behavior [18].

The model highlights a number of fundamental ideas. Women must first identify a health issue or worry, in this case, the menopausal transition and the physiological and psychological changes that go along with it. Secondly, the perceived vulnerability and severity of prospective health hazards, including obesity, cardiovascular disease, type 2 diabetes, osteoporosis, sarcopenia, and reduced quality of life, impact on women's behavior [20]. Third, when weighing the anticipated advantages of changing to a healthier lifestyle against the perceived obstacles to action, the decision to engage in preventative activities, like physical activity, is connected. Financial limitations, a lack of family or medical assistance, time constraints, and a lack of exercise options are some examples of barriers.

Self-efficacy, or the conviction that one can act in spite of challenges, is an essential extra element of HBM. Menopausal women's self-efficacy is a reflection of their confidence in their ability to overcome sociocultural obstacles, manage symptoms, and include physical activity in their daily routines. HBM offers an organized framework for analyzing participant narratives regarding physical activity in this study, emphasizing how attitudes toward risks, rewards, and obstacles influence behavior. By using this framework, the study not only documents the lived experiences of women but also places them in

a theoretical context that guides culturally appropriate health promotion tactics [21,22]

Rationale for addressing physical activity levels among Bahraini menopausal women

A major phase in women's life, menopause is characterized by a decrease in estrogen production and the emergence of a variety of physical and psychological symptoms [23]. The decrease in physical activity that frequently coincides with this stage of life is one cause for concern. Research indicates that decreased physical activity following menopause increases the risk of metabolic diseases, obesity, cardiovascular disease, and osteoporosis.

Considering lifestyle-related diseases are so common in Bahrain, these risks are especially worrisome. Bahraini women tend to have sedentary lives, and their lack of exercise greatly increases their risk of obesity, diabetes, and cardiovascular disease [24]. A serious public health concern is the decrease in physical activity during and after menopause, which not only exacerbates the burden of symptoms but also raises the risk of long-term health problems.

Social and cultural factors make this issue much more challenging. Bahraini women manage social expectations, family obligations, and traditional gender norms, which frequently restrict their access to organized exercise [25]. Social stigma, restricted access to facilities reserved for women, and restrictions on women's participation in sports can all lead to feelings of loneliness and a decrease in the desire to be physically active. These cultural considerations highlight the significance of culturally responsive interventions that empower women to put their health first.

Regular bodily activity has been demonstrated to improve psychological well-being, social ties, and self-esteem while reducing common menopausal symptoms like mood swings, sleep disruptions, and hot flashes. In addition to its positive effects on personal health, exercise promotes resilience and community involvement, two qualities that are crucial for Bahraini women who juggle many social responsibilities [26].

Thus, this work is important and timely. It makes a distinctive contribution by concentrating on Bahraini menopausal women, a group that is still underrepresented in studies. Although there is evidence from around the world that physical activity has a role in menopause, little is known about how Bahraini women view and overcome social and cultural barriers to exercise. Using a qualitative methodology, this study documents women's motivations, beliefs, and lived experiences while interpreting their actions using the Health Belief Model.

The results will guide public health programs and give useful information for community organizations,

legislators, and medical professionals. Creating culturally aware plans to increase women's physical activity can help the Bahraini government achieve its larger objectives of lowering the burden of non-communicable diseases and encouraging healthier lives for all ages.

In conclusion, encouraging physical activity in Bahraini menopausal women involves more than just encouraging them to exercise more; it also aims to improve their quality of life, empower them to take charge of their health, and build their ability to bounce back from menopause-related setbacks.

Purpose of the study

This study aims to investigate postmenopausal Bahraini women's perspectives and lived experiences of physical exercise, paying special attention to how they perceive its connection to menopausal symptoms and long-term health. The study also aims to investigate how women's motivation to participate in physical exercise is influenced by their families, communities, and healthcare professionals. The research attempts to produce culturally grounded insights that can guide specific public health interventions in Bahrain by placing these narratives inside the Health Belief Model (HBM).

Research objectives

General objective: To investigate how Bahraini postmenopausal women view and experience physical activity beyond menopause, as well as how their motivation and involvement are impacted by their families, communities, and healthcare providers.

Specific objective:

To critically explore the attitudes and perspectives of Bahraini women in the postmenopausal phase who are 50 years and above, with reference to physical exercise.

To identify the complex link between physical exercise and menopausal symptoms, highlighting the basic behavioral and psychosocial factors at play.

To identify and investigate important environmental, cultural, social, and psychological barriers and facilitators that affect physical activity participation.

To evaluate how healthcare interventions, community networks, and family dynamics affect the promotion or inhibition of physical activity behaviors.

To generate practical, culturally appropriate insights that inform evidence-based public health plans and initiatives targeted at enhancing physical activity and general health in postmenopausal Bahraini women.

Research Questions

How do postmenopausal Bahraini women 50 years and above see, understand, and engage in physical activity?

How do postmenopausal women perceive and connect exercise to the control of menopausal symptoms, such as mood swings, sleep issues, and hot flashes?

What environmental, social, cultural, and psychological elements support or undermine continued physical activity following menopause?

What effects do healthcare providers, social networks, and family dynamics have on postmenopausal women's support, motivation, and engagement in physical activity?

Methodology

Participants in this study were 25 Bahraini women who were 50 years and above. Every participant was postmenopausal and represented a range of educational, occupational, and marital circumstances. Their collective experiences offered a profound and culturally informed insight into Bahraini women's perceptions and experiences of physical activity following menopause.

Five main themes and numerous subthemes were found by manually analyzing the interview transcripts and written narratives. Within the sociocultural framework of Bahraini society, these themes represent the participants' attitudes, driving forces, and obstacles to physical activity.

The results show that people view physical activity as a wider lifestyle practice that includes everyday movement, social interaction, and spiritual well-being rather than just formal exercise. According to the participants' testimonies, community norms, family responsibilities, and personal health beliefs all have a big impact on how active they are.

To preserve authenticity and emphasize individual voices, each theme is explained in length below and backed up with actual quotes from participants. The Health Belief Model (HBM), which emphasizes the interaction of perceived barriers, perceived advantages, and self-efficacy in influencing women's health behaviors during the postmenopausal phase, serves as a framework for interpreting these findings

Setting and participants

The researcher is currently employed at the three accredited healthcare facilities in Bahrain, including a private healthcare institution in Bahrain, where this study was carried out. The hospital serves a wide range of women from different socioeconomic backgrounds, which makes it an appropriate setting for investigating attitudes toward menopause and physical activity.

Inclusion criteria: Participants were eligible for inclusion if they met all of the following criteria:

Age and menopausal status: Bahraini women aged 50 years and older who had experienced natural

menopause, defined according to the World Health Organization criterion of 12 or more consecutive months of amenorrhea not attributable to pregnancy, lactation, or medical intervention.

Most participants were married, with a smaller proportion widowed; the time since the onset of menopause ranged from 8 to 20 years.

Residence and accessibility: Permanent residents of Bahrain, living in the community (not institutionalized), and accessible for in-person or virtual interviews.

Cognitive and communicative ability: Cognitively intact and able to comprehend the study purpose, provide informed consent, and communicate personal experiences in Arabic and English.

Physical function: Ambulatory or independently mobile (with or without assistive devices) so that their experiences could reasonably reflect participation or non-participation in physical activity practices.

Experiential relevance: Self-reported personal experience of engaging in, attempting to engage in, or intentionally abstaining from physical activity following menopause, thereby contributing relevant narrative data to the study aims.

Willingness to participate: Voluntarily agreed to participate in the study and to share lived experiences in a confidential, recorded interview.

Women with considerable cognitive impairment or any medical condition that prevented them from meaningfully participating in the interview process were excluded.

The hospital's social media accounts (Facebook and Instagram), which are important outreach channels for community health involvement in Bahrain, were used for recruitment. The study's goals, methods, and ethical protections were thoroughly described to interested women during an in-person information session held at the hospital. Before participating, women who agreed to participate submitted written informed consent forms.

Exclusion criteria : Participants were excluded if they :

Had premature or surgically induced menopause (before age 40),

We are currently undergoing oncological treatment or have had an acute medical crisis that could distort our experience of regular post-menopausal activity,

Had severe cognitive impairment (e.g., advanced dementia) that precluded meaningful consent or participation, or

Declined to provide written informed consent.

Design plan

The study used a narrative method and a simple qualitative research design to investigate how women

see physical exercise during menopause. Because it enables participants to offer personal narratives that illuminate how they interpret their social surroundings and health behaviors, this design was chosen.

An in-depth comprehension of lived experience is made possible by narrative inquiry, which focuses on how people use stories to comprehend their reality. The methodology used in this study allowed postmenopausal Bahraini women to discuss their experiences with physical exercise, pinpoint cultural and personal obstacles, and consider the ways in which their families, communities, and medical professionals affect their behavior. As a result, this approach was ideal for the study's goal of comprehending the complex relationship between women's health attitudes and behaviors and their sociocultural surroundings.

Procedure

To maintain privacy and comfort, data collection was conducted in a calm, private consultation room at three accredited healthcare facilities in Bahrain. Depending on their preference, each participant attended a face-to-face interview in either Arabic or English that lasted between thirty to forty-five minutes. Before the interview, the researcher went over the goals and methods of the study and got written informed consent, which included agreement to record the interview on audio.

The semi-structured interview was performed utilizing the open-ended guidance after the participants had finished their brief written narrative. While remaining impartial and sympathetic throughout the conversation, the researcher employed reflective listening strategies and probing questions to uncover deeper insights and clarify responses.

The researcher recorded all of the interviews in audio and then transcribed them verbatim. Following every session, field notes were taken right away to record contextual observations, research reflections, and nonverbal cues. These notes subsequently bolstered interpretation and improved the analysis's credibility.

Participants were informed that there would be no repercussions if they chose not to respond to any questions or if they left the study at any time. If any participant seemed emotionally distressed while talking about delicate health-related situations, short breaks were provided to ensure comfort.

Data analysis plan

Manual thematic analysis was used to examine the data, adhering to the generally recognized six-phase framework put forward by Braun and Clarke [27]. This method was selected due to its adaptability and capacity to fully convey the richness and variety of participants' meanings and experiences. Because thematic analysis enables the methodical identification of patterns

and themes across participant tales while retaining sensitivity to context and language, it was especially well-suited for the narrative design of this study.

Further analytical procedures were carried out:

Familiarization with the data: The researcher meticulously examined the written narratives and transcribed every audio interview. Reading the transcripts several times ensured that participants were fully immersed in the data and that their points of view were initially understood.

Generating initial codes: To find significant textual units, line-by-line coding was done by hand. Inductively generated codes that reflected the language and expressions of the participants were grouped together using colored annotations.

Searching for themes: Researchers looked for conceptual connections and recurring patterns in the coded material. Preliminary themes representing more general concepts or experiences were formed by grouping related codes together. Data collection continued until thematic saturation was reached; after the 22nd interview, no new themes or subthemes emerged, and three additional interviews were conducted to confirm that saturation had been achieved.

Reviewing themes: In order to be sure, they appropriately reflected the participant narratives, the first themes were examined and improved by ongoing comparison throughout the dataset. When necessary, subthemes were found, and redundant or overlapping codes were combined.

Defining and naming themes: Every subject was precisely identified, given a name, and backed up by insightful, illustrated quotations taken straight from participant interviews and narratives. Transparency and a link between the data and interpretation were therefore guaranteed.

Producing the report: The last step was combining the elements into a cohesive story that represented Bahraini women's views on exercise following menopause. The Health Belief Model (HBM) served as the framework for interpretation, which connected the themes found to concepts including perceived advantages, barriers, and self-efficacy.

Developing ideas, analytical choices, and the researcher's reflections were recorded during the analytical process via reflexive journaling and note writing. This procedure improved dependability, trustworthiness, and reliability.

Recruitment procedures: The official social media platforms of three accredited healthcare facilities in Bahrain, including Facebook and Instagram, which Bahraini women frequently utilize to obtain health-related information, were used to recruit participants

for this study. The goal of the study, the eligibility requirements, and the contact information for participation were all detailed in an invitation post.

Women who satisfied the requirements for inclusion and showed interest were invited to the hospital for an information session. The researcher went over the study's objectives, the interview process, the anticipated length of participation, and the possibility of emotional distress while talking about personal health experiences during this session. Confidentiality, anonymity, and voluntary involvement were guaranteed to participants. Prior to data collection, those who consented to participate were asked to give written informed consent, which included consent for their interviews to be recorded on audio and transcribed.

Interviews were conducted until data saturation was reached, which is when no new themes or insights emerged. This strategy made sure that the information gathered was thorough and accurately reflected the range of experiences that women in the target age group had.

Interviews were arranged at times that worked for the participants in order to promote participation, and the hospital setting offers a relaxed and confidential atmosphere for conversation. Participants received gratitude for their time and efforts to study, but no financial incentives were provided.

Data collection tools

To collect rich and significant data from participants, two complementary qualitative methods were used: Semi-structured interviews and written narratives. These resources were selected to enable participants to reflect (in writing) and interact (in conversation) with one another regarding their experiences and perspectives of physical exercise following menopause.

Written narrative reflections: Every participant was asked to compose a brief narrative (between 200 and 300 words) outlining her thoughts on physical exercise following menopause, her level of activity at the moment, and any menopausal symptoms she may have had. This method helped build rapport during follow-up conversations and prompted participants to think carefully about their lived experiences prior to the interview. It has been demonstrated that narrative writing enhances the interpretative depth feature of qualitative inquiry and elicits genuine narratives of human experience.

Semi-Structured Interviews: The researcher performed a semi-structured interview in a private room at the three accredited healthcare facilities in Bahrain, after reviewing the written account. With the participant's permission, the 30- to 45-minute interview was audio recorded. Four open-ended questions from an interview guide were used to steer the conversation

and investigate participants' attitudes, obstacles, and reasons for engaging in physical exercise during menopause. Among the guiding questions:

What do you think about exercise following menopause?

What obstacles do you encounter when working out?

What drives you to engage in physical activity?

Are you experiencing any menopausal symptoms, and do you believe that exercise has an impact on them?

To promote elaboration and make meanings clear, the interviewer employed introspective and probing tactics. Due to practical and ethical constraints, direct field observations were not possible; rather, post-interview field notes were used to document contextual information and nonverbal clues. In order to guarantee rigor, the method adhered to a "data collection cycle," which included selecting appropriate participants and a suitable venue, gaining informed consent, gathering in-depth interviews and narratives, precisely capturing and archiving data, and upholding ethical integrity at all times.

Data richness and saturation, rather than statistical computation, influence sample size in qualitative research, especially in narrative designs. Recruitment went on until no fresh viewpoints or insights surfaced, a sign of data saturation. An anticipated sample size of five to thirty participants was deemed sufficient to obtain depth, diversity, and contextual awareness in accordance with best practices for story research. Achieving depth of understanding and documenting a range of experiences within realistic time, access, and budget limits were thus prioritized.

Trustworthiness and reflexivity

In order to guarantee that the results of this qualitative narrative study appropriately reflected the lived experiences of Bahraini women 50 years and above with regard to physical activity following menopause, establishing trustworthiness was a key factor. All phases of the study process were governed by the concepts of transferability, confirmability, credibility, and dependability.

Credibility: Several tactics were used to establish credibility in order to guarantee that the experiences of the participants were accurately portrayed. In a familiar and cozy hospital setting, all interviews were held in the participants' preferred language, either Arabic or English. This encouraged transparency and lowered obstacles to communication. Active listening combined with extended participation throughout each interview prompted participants to go into great detail about their experiences. After transcribing, the researcher did member verification by summarizing the important

ideas to participants to guarantee their meanings were accurately represented. The incorporation of audio recordings significantly boosted accuracy by providing a comprehensive examination during transcription and analysis.

Translation and transcription: Interviews were conducted in either Arabic or English, depending on each participant's preference. All Arabic interviews were transcribed verbatim in Arabic first, then translated into English by a certified bilingual translator familiar with healthcare terminology. A second independent translator conducted back-translation of 20% of the transcripts to ensure semantic accuracy. Coding was performed primarily in the original interview language, with English translations used for team discussion and reporting. Discrepancies in translation were resolved through consensus between the translator and the lead researcher.

Dependability: With a methodical and open approach to data gathering and analysis, reliability was created. Throughout the study, a research logbook was kept documenting the steps taken, the analytical choices made, and the reflections made while developing the themes and categorizing the data. This audit trail made it possible for participants to be consistent and guaranteed that other researchers could follow and validate the procedure. In accordance with the narrative approach, manual coding was purposefully employed to preserve intimate interaction with the material.

Confirmability: Constantly practicing reflexivity improved confirmability. Self-awareness was essential to reducing bias because the researcher was employed by the same medical facility where participants were gathered. Following each interview, personal reflections, possible assumptions, and emotional responses were recorded in a reflexive journal. These thoughts made it easier to separate the opinions of the participants from the researcher's interpretations and made sure that conclusions were based on the facts rather than preconceived notions [28].

Transferability: Highly detailed explanations of the participants' backgrounds, the hospital environment, and Bahraini society's cultural backdrop were provided to enhance transferability. With the use of these specifics, readers can determine whether the results might apply to comparable demographic or cultural groups.

Peer debriefing: Finally, peer debriefing with experienced qualitative researchers was used to discuss emerging codes and thematic structures. This process strengthened the credibility and analytical coherence of the study. Through these combined strategies, the study ensured a rigorous, reflective, and transparent process that upheld qualitative trustworthiness standards.

Ethical considerations: Ethical approval for this study was obtained from the ethics committee of European Institute of Technology and Technology, Switzerland (EIMT, 2025/1099/22). All procedures conformed to the principles of the World Medical Association Declaration of Helsinki and complied with the national ethical regulations governing research with human participants [29].

All participants received a detailed information sheet explaining the purpose of the study, the data collection procedures, potential risks, and their rights as research participants. They were informed that participation was voluntary and that they could withdraw from the study at any time without any negative consequences or impact on their healthcare services.

Written informed consent was obtained from each participant before data collection began. Consent included permission for the interview to be audio recorded and for the use of anonymized quotations in the final report and publication. Participants were assured that their identities would remain confidential and that any identifying details would be removed from the transcripts. Each participant was assigned a unique code number to ensure anonymity during analysis and reporting.

Given the sensitive and personal nature of discussing menopause and physical activity, steps were taken to minimize potential discomfort. Interviews were conducted in a private consultation room within the hospital to ensure privacy and emotional comfort. Participants were encouraged to skip any question they did not wish to answer, and psychological support was available through the hospital's counseling department if needed.

All digital recordings and transcripts were stored on a password-protected computer accessible only to the researcher. Hard copies of consent forms were kept in a locked cabinet at the hospital's research office. Data will be securely stored for five years following publication and then permanently deleted or destroyed, in accordance with institutional data management policy.

By following these ethical standards, the researcher ensured that participants' dignity, rights, and well-being were protected throughout the study.

Result

A total of 25 Bahraini women aged 50 years and above participated in this study. Thematic analysis of their in-depth interviews revealed a multifaceted understanding of physical activity after menopause, influenced by personal beliefs, cultural expectations, health perceptions, and social environments. Through a process of manual thematic analysis, five overarching themes and several subthemes were identified,

capturing participants lived experiences, perceived barriers, motivators, and support systems. To illustrate the richness and diversity of these perspectives, direct quotes from participants are incorporated throughout this section, providing authentic insight into their voices and lived realities.

Participant characteristics

The study included 25 Bahraini women aged between 50 years and above (mean age = 66.4 years). All participants were postmenopausal and represented diverse educational, occupational, and socioeconomic backgrounds. Most participants were retired or homemakers, while a few continued part-time community or volunteer work. The majority were married or widowed and lived with family members, reflecting traditional Bahraini household structures.

Participants' self-reported health conditions varied, with several mentioning chronic illnesses such as hypertension, arthritis, or diabetes, which influenced their physical activity choices and limitations. Despite these challenges, many expressed a strong desire to remain active, emphasizing the importance of walking, light exercises, and faith-related activities (e.g., prayer movements) in maintaining health and mobility (Table 1).

Thematic map

A thematic map was developed to visually represent the five major themes and their interconnections as identified through manual thematic analysis. The map illustrates how Bahraini women's perceptions of physical activity after menopause are shaped by personal, cultural, spiritual, and environmental influences. Each theme interacts dynamically with the others, reflecting the multidimensional nature of women lived experiences (Figure 1).

Table 1: Participant demographic characteristics.

Variable	Category	Frequency (n = 25)	Percentage (%)
Age Group (years)	50-54	9	36
	55-59	8	32
	60-64	5	20
	65 +	3	12
Marital Status	Married	13	52
	Widowed	9	36
	Single/Divorced	3	12
Education Level	Primary or less	10	40
	Secondary	8	32
	University or higher	7	28
Employment Status	Retired	11	44
	Homemaker	10	40
	Part-time/Volunteer	4	16
Chronic Health Conditions	Yes	15	60
	No	10	40

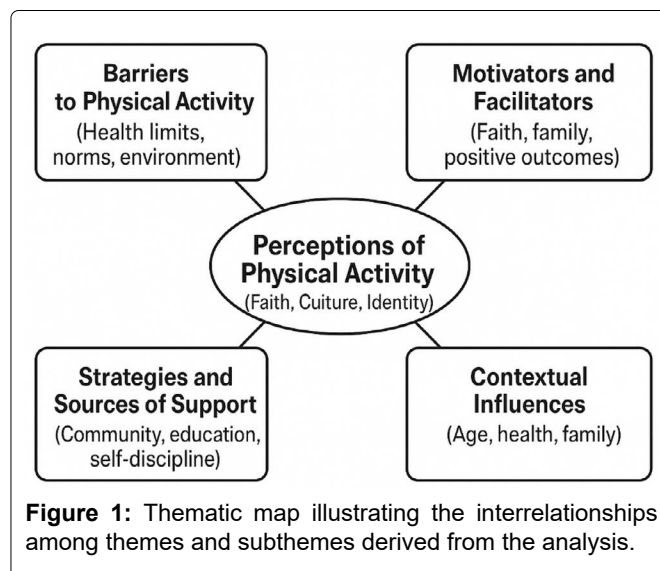


Figure 1: Thematic map illustrating the interrelationships among themes and subthemes derived from the analysis.

Presentation of thematic map

Thematic analysis of participants' narratives revealed five major themes and several interrelated subthemes, as shown below:

Theme 1: Perceptions of Physical Activity

Theme 2: Barriers to Physical Activity

Theme 3: Motivators and Facilitators

Theme 4: Strategies and Sources of Support

Theme 5: Contextual Influences

Perceptions of physical activity: Participants' understanding of physical activity after menopause extended beyond exercise routines; it was intertwined with notions of faith, aging, and self-respect. For women aged 50 years and above, physical activity was often described as a way to preserve dignity, mobility, and independence rather than merely achieving fitness or appearance.

Many participants describe physical activity as a natural and spiritual practice embedded in daily routines, such as prayer, household chores, walking to the market, and caring for grandchildren. These activities were viewed not as chores but as integrated practices that connected the body, mind, and spirit.

"For me, moving is part of my faith," shared a 67-year-old participant. "When I pray, I feel my body stretch and my soul rest. That is my kind of exercise."

As women aged beyond 50 and advanced further into post-menopause, they reported a shift in how they valued movement. In their younger year, exercises were often perceived as optional, sometimes linked to body image or social trends. In later years, it becomes a means of sustaining health, independence, and gratitude for continued mobility.

Several women reflected that their perception of activity had evolved with age. Younger versions of

themselves might have viewed exercise as something optional or aesthetic, but in later years, it became a matter of health preservation and gratitude.

“When I was younger, I never thought about walking for health,” noted a 62-year-old participant.

Noted another.

“Now, every step feels like a blessing from God, a chance to stay alive and connected.”

For some, the cultural and gendered meanings of movement shaped how they viewed physical activity. Traditional expectations around modesty, caregiving, and family responsibilities sometimes limited women’s engagement in structured exercise, yet many found alternative ways to remain active within accepted social boundaries.

“We were taught to stay at home and look after the family,” explained one 70-year-old widow.

“But I realized that sweeping the house, gardening, and praying five times a day—all these are also movements that keep me healthy.”

Overall, participants’ narratives revealed that physical activity after age 50 is not a singular concept but a holistic expression of wellness-rooted in faith, shaped by cultural norms, and redefined through the experience of aging and years since menopause. For these women, movement was a means of sustaining functionality, independence, and gratitude in later life.

Theme 2: Barriers to physical activity: While participants expressed strong appreciation for staying active, they also described numerous barriers that hindered their engagement in regular physical activity. These barriers stemmed from health-related, social, cultural, and environmental factors, and were often intensified by the challenges of aging after menopause.

Health limitations and aging fears: Women aged 50 years and above frequently reported that age-related health conditions constrained their ability to remain active. Chronic conditions such as arthritis, knee pain, hypertension, and diabetes were common, limiting endurance and mobility. Some participants associate aging with inevitable physical decline, perceiving exercise as risky or unnecessary.

“My knees hurt after a short walk,” shared a 72-year-old woman. “I’m afraid if I fall, I won’t get up again. So, I prefer to stay safe and do light work at home.”

Participants also noted that health-care providers seldom encouraged older women to exercise, which contributed to inactivity and feelings of resignation.

“Doctors tell me to rest because of my blood pressure”, explained 66-year-old woman.

Others mentioned that health professionals rarely encouraged them to remain active, reinforcing the

belief that older women should avoid exertion. This lack of medical reinforcement contributed to inactivity and feelings of helplessness.

Societal expectations and gender norms: Cultural perceptions surrounding female modesty and aging were another significant barrier. Several women felt that exercising outside the home or attending public fitness centers was socially uncomfortable or inappropriate, particularly without female-only facilities.

“We grew up being told not to show our bodies or move too freely,” explained a 68-year-old participant. “Even if there’s a ladies’ gym, I feel shy to go.”

Traditional gender roles also limited time and energy for self-care. Many participants prioritized family duties—such as caring for grandchildren, cooking, or managing household tasks—over personal health activities, reflecting a deep-seated sense of duty and sacrifice.

“My time belongs to my family,” said a 65-year-old homemaker. “By the end of the day, I’m too tired to think about exercise.”

Environmental and accessibility challenges: Participants also highlighted the lack of safe, age-friendly spaces for physical activity. Uneven pavements, poor lighting, and limited access to parks or walking trails were common concerns, particularly for older women in suburban or rural areas.

“The roads are not safe for walking,” noted a 70-year-old widow. “Cars pass too close, and there are no sidewalks. Even when I want to walk, I worry.”

Moreover, Bahrain’s hot climate was seen as a physical deterrent, making outdoor activity uncomfortable for much of the year. The absence of affordable, culturally appropriate indoor spaces further exacerbated this issue.

“In summer, it’s impossible to walk outside.” shared another.

“We need places where women can move freely without feeling exposed or judged.”

Overall, the experiences of women aged 50 years and above highlight how health concerns, cultural expectations, caregiving responsibilities, and environmental constraints intersect to hinder consistent physical activity after menopause. These barriers reflect not only individual health limitations but also structural and cultural factors, underscoring the importance of age-sensitive, gender-appropriate, and context-specific interventions to support active living for older Bahraini women.

Theme 3: Motivators and facilitators: Despite the many barriers faced, participants aged 50 years and above describe the range of personal, social, cultural, and spiritual motivators and facilitators that inspired or enabled them to engage in physical activity. These

included family encouragement, faith-based motivation, positive health experiences, and community influence. Together, these factors provide emotional resilience, spiritual meanings, and practical support for maintaining movement in daily life.

Family encouragement and social support: Family members—especially children and grandchildren played a central role in motivating older women to remain active. Many participants mentioned that encouragement from loved ones gave them both confidence and purpose.

“My daughter always tells me, ‘Mama, go for a walk, it’s good for your heart.’ When she joins me, I feel young again,” said a 64-year-old participant with a smile.

This intergenerational involvement often transformed physical activity into shared family time, strengthening emotional bonds while promoting health. Some women reported that seeing younger relatives exercise motivated them to follow their example, highlighting the power of social modeling in encouraging activity.

“When I see my grandchildren running, I think, Why not me? I walk slowly, but at least I move,” shared a 70-year-old grandmother.

Faith-Driven motivation: For many women, faith was the deepest and most enduring motivator. Participants frequently described movement as an act of worship, gratitude, and connection to God. Engaging in physical activity was viewed as honoring the body that Allah had entrusted to them.

“Our bodies are a gift from Allah,” reflected one 66-year-old woman. “Keeping it active and clean is a form of prayer.”

The spiritual aspect of prayer movements (e.g., bowing, kneeling, and standing) was often recognized as a natural exercise routine that reinforced flexibility and mindfulness. This alignment between faith and physical well-being helped participants maintain a positive relationship with their bodies, even amid illness or aging.

“When I pray, I stretch my body and my soul together,” said another. “It keeps me balanced inside and out.”

Positive health outcomes and self-worth: Several participants shared that noticing improvements in health or mood after regular walking or stretching encouraged them to continue. Small achievements—such as reduced stiffness, better sleep, or lowered blood pressure—served as powerful reinforcements for maintaining activity.

“Before, I used to wake up with pain in my joints,” explained a 69-year-old participant. “After I started walking daily, I sleep better and feel lighter.”

Beyond physical health, many women linked movement to self-worth and independence. Staying active was a way of asserting control over their lives and defying societal expectations that older women should be passive.

“People think old age means sitting still,” said one participant firmly. “But I want to prove that I can still do things for myself.”

Community and peer influence: Although less frequent, a few participants mentioned community-based activities—such as group walks, mosque gatherings, or senior wellness programs—that provided structure and social enjoyment. Peer companionship reduced feelings of isolation and boosted confidence.

“I joined a small walking group in my neighborhood,” shared a 63-year-old.

“We talk, we laugh, and it makes the walk easier. It’s not just about the exercise; it’s about being together.”

These experiences demonstrated how Bahraini women aged 50 years and above are socially connected and collective motivation could help sustain active lifestyles, especially in later life when loneliness or fatigue might otherwise discourage participation. The motivators and facilitators were multifaceted, blending family support, faith-based meaning, visible health benefits, and opportunities for community connection. These factors often counterbalanced the physical and social barriers of aging, helping women to sustain movement not only as a health behavior but also as a source of dignity, purpose, and belonging in later life.

Theme 4: Strategies and sources of support: Participants described a range of adaptive strategies and support systems that helped them maintain some form of physical activity despite health limitations, cultural constraints, or environmental challenges. These strategies reflect creativity, determination, and reliance on faith, community, and self-discipline to stay active and positive.

Community programs and peer influence: Several participants mentioned that attending community or mosque-based programs encouraged them to participate in regular movement, even if informally. While such programs were not widespread, women who had access to them valued the social engagement and sense of belonging they offered.

“At our local women’s center, we meet twice a week,” said a 64-year-old participant.

“We do simple stretches and talk about health. It feels good to move together.”

Peer influence also played a motivating role. Seeing others of the same age remain active inspired participants to imitate healthy behaviors and exchange advice.

“When I see my friend walking every morning, I tell myself, I can do that too,” explained a 70-year-old woman.

“We encourage each other.”

These social connections created informal support networks that helped sustain engagement and reduced feelings of isolation among older women.

Healthcare guidance and education: Participants emphasized the importance of trustworthy health information and encouragement from healthcare professionals. Those who received medical advice or educational sessions about safe exercises were more likely to engage in daily movement.

“The nurse told me that walking for 20 minutes every day can lower my sugar.”

Recalled a 67-year-old woman with diabetes.

“Now I try to walk after breakfast. It’s simple but helpful.”

However, some participants noted the lack of targeted programs or counseling for older women, suggesting a need for more age-appropriate, culturally sensitive guidance from healthcare providers. They expressed interest in educational workshops focusing on home-based exercises that could be done safely and privately.

“I wish there were classes just for older women,” said one 72-year-old.

“We need someone to teach us what movements are safe for our age.”

Self-Discipline and personal adaptation: Many participants relied on self-motivation and adaptability to stay active within their comfort zones. They described incorporating movement into everyday tasks—cleaning, gardening, or walking during errands as practical strategies for maintaining mobility.

“I may not go to the gym,” shared a 66-year-old widow, “but I move around the house, stretch my arms, and keep busy. That is my exercise.”

Others used self-talk and goal setting to maintain consistency, viewing each small effort as an achievement. Even in the absence of formal programs, they found personal ways to adapt to their environment and health limitations.

“I tell myself every morning, don’t sit too long,” said another. “I put on the radio, move my hands, or walk while cooking. Movement is movement.”

Faith and inner strength: Spirituality emerged again as a powerful source of emotional resilience and perseverance. Prayer, recitation, and reflection provided mental peace and motivation to overcome fatigue or discouragement. Many women described a

sense of divine companionship in their efforts to stay active.

“When I feel lazy, I remind myself that Allah gives me strength,” said a 68-year-old participant. “If I move, it’s because He allows me to move.”

For some, gratitude itself was a form of motivation. Recognizing movement as a blessing inspired them to persist despite pain or aging: “Every time I can stand and walk to pray, I thank God,” shared another. “Many cannot. So I move with gratitude.”

Theme 5: Contextual influences: Women’s engagement in physical activity after menopause was deeply shaped by the broader cultural, environmental, and social contexts in which they lived. These contextual influences included the hot climate, limited access to gender-appropriate facilities, cultural expectations, and family responsibilities. Participants described how these factors interacted to either discourage or, in a few cases, indirectly motivate them to remain active.

Many women noted that Bahrain’s extreme heat restricted outdoor activity for much of the year. Several participants explained that even early morning walks were often uncomfortable, and safe, shaded areas were limited. One participant reflected:

“When the sun rises, you cannot walk outside - the heat drains your energy. I tried going in the evening, but the air is still heavy.”

Access to indoor exercise spaces was also described as limited, especially for older women who preferred women-only environments. Social norms regarding modesty and gender segregation influenced their comfort levels in participating in public exercise. As one woman explained:

“I would join a gym if it were only for women. But most are mixed or far away. It doesn’t feel right at my age.”

Cultural perceptions of aging and femininity further shaped attitudes toward physical activity. Some participants felt that engaging in structured exercise at an older age might be viewed as unnecessary or even inappropriate. Family expectations, particularly caregiving duties for grandchildren and household responsibilities, also limited the time and energy available for self-care.

“My daughter works, so I take care of her children. After a full day with them, I have no strength left to walk or move for myself,” shared one grandmother.

Despite these barriers, a few participants identified how family or community support could create positive contextual change. Some women reported that when health campaigns, mosques, or local centers promoted physical activity for older women, it helped normalize the idea.

“When they talk about health at the women’s center, I feel encouraged. It reminds us that taking care of our bodies is part of taking care of our faith.”

Overall, this theme underscores that women’s physical activity behaviors after menopause are not shaped in isolation but are interwoven with Bahrain’s cultural expectations, environmental realities, and social responsibilities. Addressing these contextual influences may be key to creating supportive, culturally sensitive programs that enable Bahraini women to maintain an active lifestyle in later life.

Thematical analysis: This study explored the perceptions and lived experiences of 25 Bahraini women aged 50 years and above regarding physical activity after menopause. Through manual thematic analysis, five major themes emerged, each reflecting a unique dimension of how older women understand, experience, and navigate physical activity within their social and cultural contexts.

1st Theme: Perceptions of Physical Activity revealed that physical activity was viewed holistically, encompassing not only formal exercise but also daily movements embedded in faith, household routines, and social life. Women perceived movement as a source of dignity, spiritual balance, and personal well-being rather than a purely physical pursuit.

2nd Theme: Barriers to Physical Activity highlighted the challenges these women faced, including chronic health conditions, fear of injury, gendered expectations, and limited access to safe or culturally appropriate exercise spaces. Environmental obstacles and social constraints reinforced inactivity, yet participants’ reflections conveyed resilience rather than resignation.

3rd Theme: Motivators and Facilitators, illustrated that family encouragement, faith, and positive health experiences acted as strong incentives to stay active. Physical activity was often driven by emotional connections, love for family, gratitude toward God, and a desire for independence in later life.

4th Theme: Strategies and Sources of Support emphasized the adaptive ways women-maintained activity despite barriers. They drew strength from self-discipline, faith, and informal community networks, integrating movement into daily routines and prayer practices.

5th Theme: Role of Healthcare and Policy Environment captured participants’ insights into the broader support systems or lack thereof that influence their physical activity engagement. Women frequently expressed the need for accessible, age-friendly healthcare guidance, culturally sensitive exercise programs, and supportive public health messaging. Several participants highlighted the absence of regular counseling on safe physical activity from healthcare providers and called for community-based, women-only spaces designed

to promote health in culturally appropriate ways. The limited visibility of policy-driven initiatives and the lack of structured wellness programs for older women were perceived as missed opportunities to improve their overall well-being.

Collectively, these findings reveal that physical activity among older Bahraini women is a deeply cultural and spiritual experience, shaped by social norms, personal faith, and community support. While barriers remain, participants demonstrated a strong sense of agency and adaptability, suggesting that faith-integrated, family-supported, and community-based approaches could be effective in promoting active lifestyles for postmenopausal women (Figure 2).

Figure 1. Thematic map linking the five emergent themes from the study to the Health Belief Model (HBM) constructs. Theme 1 (Perceptions of Physical Activity) connects to perceived benefits and cues to action; Theme 2 (Barriers) aligns with perceived barriers; Theme 3 (Motivators & Facilitators) links to perceived benefits and cues to action; Theme 4 (Strategies & Support) reflects self-efficacy and enabling factors; and Theme 5 (Role of health care & policy environment) (Table 2).

Table 1. This table illustrates how the five emergent themes from the qualitative study-Perceptions of Physical Activity, Barriers, Motivators and Facilitators, Strategies and Sources of Support, and the Role of Healthcare and Policy Environment align with the key constructs of the Health Belief Model (HBM). Each theme is linked to its corresponding HBM construct and is supported by representative participant quotations that capture the lived experiences of Bahraini women aged 50 years and above.

Discussion

This study explored the perceptions and lived experiences of Bahraini women aged 50 years and above regarding physical activity after menopause. Thematic analysis revealed five major themes:

Perceptions of Physical Activity after Menopause,
Perceived Barriers,
Motivators and Personal Drivers,
Social Support and Community Influence, and

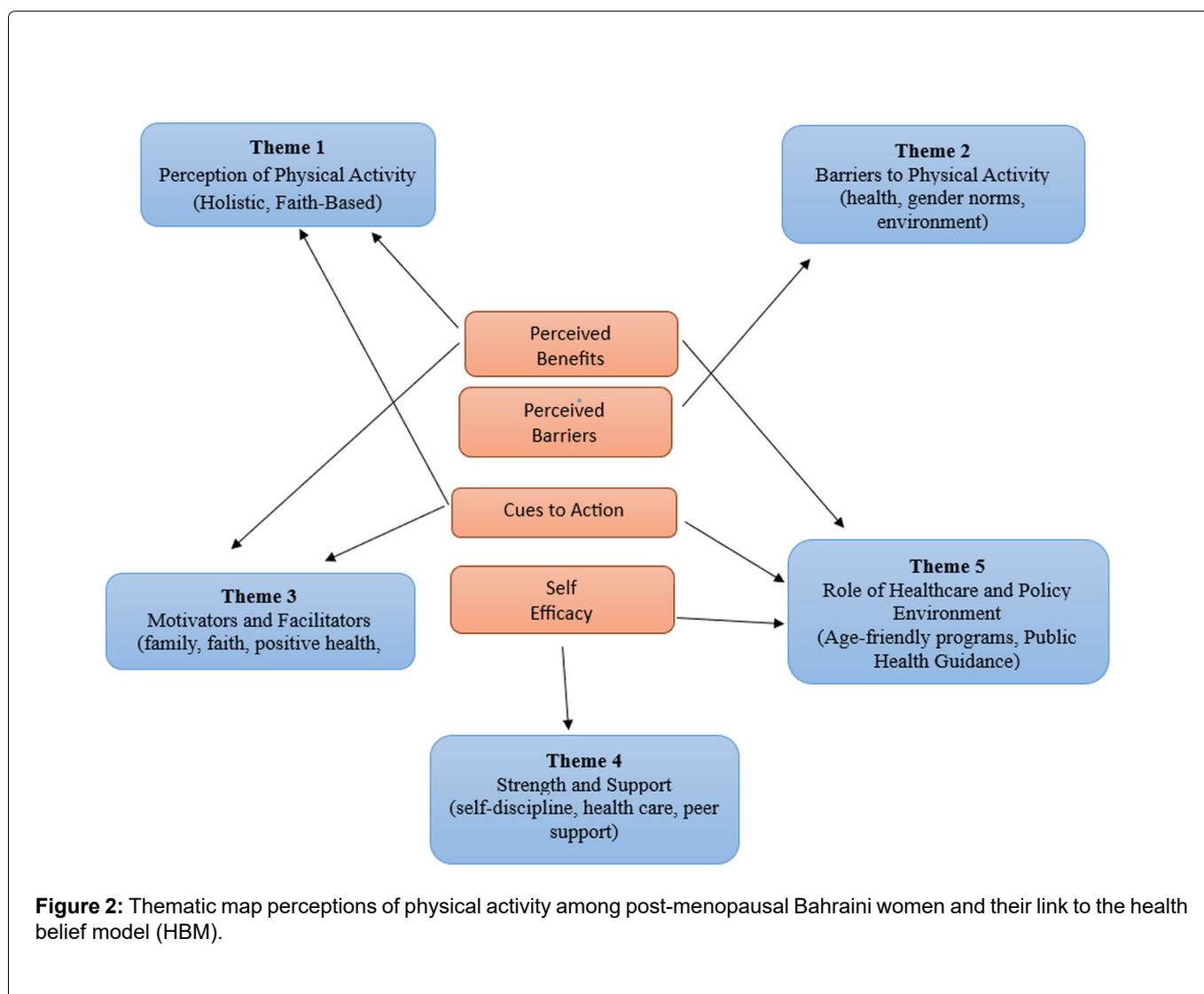
Contextual Influences. Collectively, these themes highlight how women’s engagement in physical activity is shaped by individual beliefs, family dynamics, and broader cultural and environmental contexts.

Perceptions of physical activity after menopause:

Participants generally viewed physical activity as a vital component of maintaining physical health, mobility, and emotional balance during aging. They recognized its role in managing weight, joint pain, and mood fluctuations, consistent with previous findings

Table 2: Mapping of the four emergent themes and sub-themes to the construction of the Health Belief Model (HBM), with representative participant quotations.

Theme	Key Sub-themes	Corresponding HBM Construct	Illustrative Quote
Theme 1: Perceptions of Physical Activity	<ul style="list-style-type: none"> • Movement as part of faith • Activity for dignity, independence, and health maintenance 	Perceived Benefits / Cues to Action	"For me, moving is part of my faith... when I pray, I feel my body stretch and my soul rest." (P12, 67)
Theme 2: Barriers to Physical Activity	<ul style="list-style-type: none"> • Chronic pain, arthritis, diabetes • Fear of injury and aging • Cultural modesty norms • Lack of safe spaces / hot climate 	Perceived Barriers	"My knees hurt after a short walk... I'm afraid if I fall, I won't get up again." (P08, 72)
Theme 3: Motivators & Facilitators	<ul style="list-style-type: none"> • Family encouragement • Faith as purpose • Visible health gains (less pain, better sleep) • Peer or community activities 	Perceived Benefits / Cues to Action	"My daughter tells me, 'Mama, go for a walk, it's good for your heart.' When she joins me, I feel young again." (P05, 64)
Theme 4: Strategies & Sources of Support	<ul style="list-style-type: none"> • Self-discipline and home-based movement • Guidance from healthcare professionals • Community/women-only programs • Spiritual resilience 	Self-Efficacy / Enabling Factors	"I tell myself every morning, don't sit too long... I move while cooking or stretch my arms." (P17, 66)
Theme 5: Role of Healthcare & Policy Environment	<ul style="list-style-type: none"> • Limited structured wellness programs for older women • Need for culturally appropriate, women-only facilities • Desire for regular counseling on safe activity • Importance of supportive public-health messages 	Cues to Action / Perceived Benefits / Self-Efficacy	"Doctors never told us that walking daily helps... we need proper advice and programs for women our age." (P19, 68)



that postmenopausal women often value exercise for its preventive benefits (Elavsky & McAuley, 2007). However, many women equated “being active” with performing daily household chores or light walking, rather than structured or moderate-intensity exercise.

This perception reflects cultural norms where activity is embedded in domestic or caregiving roles, rather than seen as a personal or recreational pursuit. Therefore, educational interventions should aim to:

Clarify what constitutes health-promoting physical activity.

Distinguish between light household movement and structured exercise.

Reinforce the value of intentional, moderate activity for long-term health.

Such culturally tailored education could help reframe physical activity as an attainable and essential component of healthy aging.

Perceived barriers

Despite understanding the benefits of activity, participants identified several barriers that restrict regular exercise. These included physical limitations, lack of time, family obligations, and environmental challenges such as extreme heat. Cultural beliefs about aging also contributed to inactivity, as some women felt that “exercise at this age is not necessary.”

Key barriers identified included:

Environmental: Bahrain’s hot and humid climate limits outdoor exercise opportunities.

Cultural: Modesty and gender norms discourage participation in mixed-gender spaces.

Physical: Chronic illnesses, pain, and fear of injury reduce confidence.

Social: Caregiving responsibilities limit time for self-care.

These findings align with regional studies in the Gulf, where social acceptability, limited infrastructure, and health conditions remain primary barriers for women (Al-Eisa & Al-Sobayel, 2012; Sharara et al., 2018). Addressing these barriers requires not only individual motivation but policy-level solutions such as accessible, women-only facilities and climate-adapted exercise environments.

Motivators and personal drivers

In contrast, several motivators encouraged participants to remain physically active. Many women cited the desire to preserve mobility, independence, and emotional well-being as strong internal motivators. Faith also played a significant role: participants viewed maintaining their health as a form of gratitude to God and stewardship of the body He provided.

Common motivators included:

Health awareness: Preventing disease and reducing pain.

Emotional well-being: Reducing anxiety, improving mood, and enhancing sleep.

Spiritual motivation: Viewing exercise as part of religious responsibility and self-care.

Independence: Desire to remain self-sufficient and avoid dependence on others.

This spiritual framing is particularly meaningful in Bahraini culture, where religiosity informs daily practices and values. Integrating Islamic principles of balance and stewardship into health campaigns may therefore enhance women’s motivation and acceptance of physical activity.

Social support and community influence

Family and community emerged as powerful enablers of physical activity. Women who received encouragement from children, spouses, or peers were more likely to remain active, while those lacking such support often disengaged. In Bahraini society, where family structures are interdependent, this social dimension significantly shapes behavior.

Participants highlighted that:

Supportive family attitudes helped build confidence to engage in activity.

Community programs and women’s centers provided safe and socially acceptable environments.

Lack of understanding from family members sometimes discouraged participation.

These findings support social-ecological models emphasizing that health behavior change requires interpersonal and environmental reinforcement [30]. Consequently, public health programs should involve family-oriented interventions, encouraging relatives to promote and participate in women’s health activities.

Contextual influences

Contextual realities, including environmental conditions, cultural expectations, and caregiving roles, deeply influenced women’s capacity to engage in physical activity. Participants frequently described Bahrain’s intense heat as a physical deterrent and cited the lack of accessible, gender-appropriate facilities as a cultural barrier. Furthermore, caregiving responsibilities for grandchildren often took precedence over personal well-being.

As participants expressed:

“After taking care of my daughter’s children all day, I have no energy left for myself.”

However, positive contextual shifts were also observed. Health promotion events at mosques or women's centers, and religiously framed wellness campaigns, encouraged participation and normalized the idea of older women exercising. These findings demonstrate that sustainable change requires creating culturally sensitive, context specific environments that enable women to prioritize their health without compromising social expectations.

Synthesis and implications

The findings collectively reveal that Bahraini women's engagement in physical activity after menopause is influenced by interconnected physical, social, and cultural factors. Awareness of benefits alone is insufficient; women need supportive environments, social acceptance, and clear, culturally grounded guidance.

Future interventions should therefore:

Promote women-only exercise programs in air-conditioned, accessible locations.

Integrate faith-based health education, emphasizing the spiritual value of self-care.

Encourage family involvement to reshape perceptions of older women's health needs.

Address policy-level barriers by investing in age- and gender-sensitive community infrastructure.

Strengths and limitations

A strength of this study lies in its focus on an underexplored population, older Bahraini women, and its qualitative depth, which captured the complexity of their experiences. However, findings are based on a relatively small, non-random sample, limiting generalizability. Future research could use mixed methods designs with larger samples to test culturally tailored interventions.

Recommendations

Based on the findings of this study, several recommendations are proposed to enhance participation in physical activity among postmenopausal Bahraini women. These recommendations are directed toward health policymakers, practitioners, and community organizations seeking to develop culturally relevant interventions.

Policy and infrastructure development

Establish women-only exercise centers that are affordable, accessible, and climate-controlled to address modesty concerns and environmental barriers.

Integrate age- and gender-sensitive design in community spaces such as parks, walking tracks, and recreation centers.

Encourage collaboration between the Ministry of

Health and local municipalities to promote safe and inclusive physical environments for older women.

Health education and awareness

Develop targeted awareness campaigns that redefine physical activity beyond household chores and highlight its preventive role in managing menopausal symptoms and chronic diseases.

Incorporate faith-based and culturally grounded messages emphasizing that maintaining physical health aligns with Islamic principles of self-care and gratitude.

Train healthcare professionals to provide personalized physical activity counseling during routine check-ups for menopausal and postmenopausal women.

Community and family engagement

Encourage family-based initiatives where spouses and children are involved in promoting women's active lifestyles.

Partner with women's associations, mosques, and senior clubs to deliver programs that combine physical, spiritual, and social well-being.

Introduce peer-led exercise groups or community walking clubs to foster motivation and reduce isolation.

Research and evaluation

Conduct longitudinal and mixed-method studies to evaluate the long-term effects of culturally adapted interventions on women's physical and psychological well-being.

Explore digital or home-based exercise solutions, especially for women with mobility limitations or caregiving responsibilities.

Conclusion

This study explored how Bahraini women aged 50 years and above perceive and experience physical activity after menopause. The findings revealed that women generally recognize the health and emotional benefits of staying active but face multifaceted challenges rooted in cultural norms, family responsibilities, environmental conditions, and limited access to suitable exercise facilities.

While physical activity was valued for maintaining mobility, independence, and emotional stability, it was often interpreted through a domestic or caregiving lens rather than as structured health behavior. Barriers such as extreme heat, lack of women-only exercise spaces, and prioritization of family duties over self-care restricted participation. At the same time, intrinsic motivation, faith, and social support emerged as powerful enablers that can be leveraged to promote active living among older women.

The study underscores that physical activity after menopause is not solely an individual decision but is

shaped by a broader socio-cultural and environmental context. Therefore, health promotion strategies in Bahrain should adopt a holistic, culturally sensitive, and community-based approach. Programs that integrate faith-based messages, provide gender-appropriate spaces, and engage families in supporting women's wellbeing are likely to have greater acceptance and sustainability.

Ultimately, promoting physical activity among postmenopausal women requires shifting the perception of exercise from a personal leisure activity to an act of stewardship and empowerment - one that honors both the body and the faith that sustains it. Supporting women to remain physically active in later life will not only enhance their health but also contribute to stronger, more resilient families and communities in Bahraini society.

While these findings highlight important cultural and contextual factors influencing physical activity among post-menopausal women in Bahrain, they are based on a small qualitative sample from three facilities. The insights should therefore be viewed as exploratory and used to inform the design of targeted pilot programs - such as culturally tailored, women-only, indoor walking or stretching groups - rather than as the basis for nationwide policy. Future larger-scale mixed-methods studies and intervention trials are needed to evaluate program effectiveness and generalizability.

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