Menosoc

Newsletter of the Menopause Society of Sri Lanka

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The Menopause Society of Sri Lanka

Council Members 2010 - 2012

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Standing rear row (L-R): Dr Prasad Rannulu (Asst. Secretary), Dr. Ms. Marlene Abeywardena, Dr. Rukshan Fernandopulle, Dr Prasantha Gange (Social Secretary)

Absent: Prof C. Randeniya (Vice President), Dr Kolitha Sellahewa (Past President), Dr. Sunil Fernando, Ms. Kumuduni Hettiarachchi, Dr. P. G. Maheepala, Dr. Noel Somasundarum, Dr. Anoma Jayathilaka, Dr. M. Chandrarathne, Dr. Neththanjali Mapitigama, Dr. Preethi Wijegunawardena, Dr. Srinath Chandrasekera

Congratulations!

Dr. M. D. P. Goonaratne was elected as the President of the South Asian Federation of Menopause Societies 2012-2014. He is the first Sri Lankan to be appointed to this prestigious position and *Menosoc* wishes him a successful term in office.

Council

President:
Dr Hemantha Perera

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Dr Rohana Haththotuwa

Vice President:
Prof C. Randeniya

Past President:
Dr Kolitha Sellahewa

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Dr. Sanath Akmeemana
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Dr. T. B. Dissanayake
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Ms. Kumuduni Hettiarachchi
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Prof. W. I. Amarasinghe
Dr. M. D. P. Goonarathne
Dr. Ananda Ranatunga

Co-opted Members
Dr. Neththanjali Mapitigama
Dr. Preethi Wijegunawardena
Ms. Wasantha Perera
Dr. Srinath Chandrasekera

Our aims are:

* To raise awareness of the menopause and its management
* To provide unbiased information
* To help women make informed decisions about their own health and wellbeing with healthcare professionals
* To inform healthcare professionals

We can help you if:

* You are approaching or going through the menopause
* You have had a hysterectomy or premature menopause
* You are post-menopausal
* You are interested in mid-life issues
* You are a healthcare professional with an interest in the menopause

Join us..

Our members receive quarterly newsletters and have access to our information service.

To join us please contact:
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Assistant Secretary
T.P: 0773732756
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www.menosocsl.org

Are women at a higher risk for CHD?

Coronary Heart Disease (CHD) is considered by many as a disease of men. But it is the commonest cause of death in women of post reproductive age. With estrogen deficiency at menopause cardio protective effect of estrogen is lost, and along with other risk factors lead to an increase of CHD with resultant increased mortality from CHD.

Data from Centers for Disease Control and Prevention in US reveal that 1 in 2.6 women die from CHD contrasted with 1 in 4.6 from cancer. However, gender differences in the clinical presentation of cardiovascular diseases have been demonstrated and some therapeutic options may not be equally effective and safe in men and women. CHD is a disease of older women as it presents 10 years later than in men. Life expectancy of women is more than that of men, and women live more than thirty years after menopause.

The lack of awareness of CHD among women is especially serious in low or middle-income countries like Sri Lanka where public health policy has been mostly focused on maternal and child health. Another possible reason may be that CHD has traditionally been perceived as a male illness despite the fact that it ends the lives of many women than men.

Higher percentage of women when compared to men dies within one year of having a myocardial infarct. As the women are older by ten years they may be having other chronic illnesses like diabetes, hypertension, renal diseases etc. and this may contribute to this increase in mortality among women.

Symptoms of women with CHD appear different from that of men, and CHD in women is often diagnosed late, and treated less aggressively. In South Asian countries there is a delay in women reaching hospital for treatment of CHD. In these countries health of the man who is the bread winner takes priority. Further women may experience symptoms incongruent with ''standard'' cardiac symptom presentation. Women and their health care providers may not associate their symptoms with CHD. Thus unusuasl presentation and the fallacy that women are less susceptible to CHD may lead to the interpretation by health professionals of women's symptoms as psychosomatic. It is also well documented that there Is, under-representation of women in cardiovascular trials.

Women report more angina despite lower rates of obstructive CAD and women have less anatomical obstructive coronary artery disease (CAD) and relatively preserved left ventricular function yet greater rates of myocardial ischemia and mortality compared with similarly aged males. Women's Ischemia Syndrome Evaluation (WISE) and related studies implicate abnormal coronary reactivity, microvascular dysfunction, and plaque erosion leading to distal microembolization as contributory to a female-specific ischemic heart disease(IHD) pathophysiology. WISE study also demonstrated increased rates of mortality in women with chest pain and no obstructive CAD i.e. with normal coronary angiogram, showing a poor prognosis in these women.

Risk factors for IHD in women

More than 80% of perimenopausal women have one or more traditional cardiac risk factors. After menopause total cholesterol and LDL-C increases, while HDL-C decreases. Obesity is prevalent in about one third of women with associated mortality.

Hypertriglyceridemia is a more potent independent risk factor for women as compared with men. Diabetic women have significantly greater rates of CHD mortality compared with diabetic men. Metabolic syndrome with increased obesity, diabetes, dyslipidemia, and hypertension, is more common in women after menopause.

In addition to the traditional risk factors women have, on average, greater mean C-reactive protein (CRP) measures compared with men; incidentally this difference in CRP is consistent with a greater frequency of inflammatory-mediated autoimmune diseases, such as rheumatoid arthritis or systemic lupus erythematosus, in women .as compared with men. The relative risk of future Ischemic Heart Disease (IHD) events increases proportionally with increasing levels of high-sensitivity CRP (hsCRP), acting synergistically with other risk factors to accelerate IHD risk in women.

Dr. M. D. P. Goonaratne
Consultant Obstetrician and Gynaecologist.
Founder President,
Menopause Society of Sri Lanka

Polycystic ovary syndrome is prevalent in 10% to13% of women and is linked with a clustering of risk factors, incident type 2 diabetes mellitus, and adverse IHD incidents in postmenopause. Clustering of risk factors are more commonly seen in women after menopause.

Smoking which is a serious risk factor for CHD is prevalent among women in western countries, while only 9% of women smoke in developing countries. According to Global Adult Tobacco Survey (GATS), in India tobacco use among women has doubled over the last five years. It is not only smoking cigarettes, but also other methods of tobacco use like smoking cigars, beedi, and chewing tobacco are hazardous to health. In Mumbai 56% of women chew tobacco. In an epidemiological survey in a village in Sri Lanka 64% of rural women were using betel quid with tobacco.

Women with diabetes have a higher risk of developing CHD than women without diabetes. Hazard ratio for coronary mortality for women with diabetes and MI is much higher than that for men. Unlike men, women with diabetes have higher levels of blood pressure and lipid changes which may contribute to this excess mortality in women. In Nurses' Health Study, it was reported that diabetes is a strong risk factor for sudden cardiac death in women with diabetes. Diabetic women have a higher incidence of cardiac arrhythmias including ventricular fibrillation. Evidence also shows that glucose intolerance as in prediabetic state can lead to changes leading to poor survival and sudden cardiac death. Those women with gestational diabetes are at a higher risk of developing diabetes after menopause. In the Framingham study diabetes was significantly associated with atrial fibrillation, more so in women.

(To be continued in the next issue)

Future Events of the Menopause Society of Sri Lanka

Workshop on post-reproductive health

Kurunegala/ Anuradhapura	12th, 13th Agugust 2012
Kegalle	17th September 2012
Monaragala	30th, 31st October 2012
Galle	4th December 2012

Lost link

Prof. Behram S. Anklesaria
MD, FICOG, FICMCH, DGO, DFP,
ATMF (Johns Hopkins,USA)

Founder President, (2010 - 2012)
South Asian Federation of
Menopause Societies (SAFOMS)

Behram was a true friend of Sri Lanka. He loved us and we loved him. Who didn't? He was the common bridge to all the neighboring countries, not just India. His perseverance was unlimited. He always had an answer and made sure it worked. Extremely knowledgeable, yet no air about it. Always thought a step ahead than the others, making our lives easy. What would be a meeting without his inimitable laughter, loving sarcasm, forceful yet smooth extraction of facts from the participants and the ever enjoyable banter. We took him for granted. He will be there when we need; That was the universal feeling. Though we should have, as all our religions teach us, we never thought about the possibility of having a regional gathering, scientific or otherwise, without him. Now it has come, like a thunder on a sunny day. "oh no!!" was the first response of every one. Those mischievous, twinkling, sharp eyes are closed. He will be always remembered, talked about and missed. But , by god, his was an innings to stay in the minds of us till we leave. We share the sorrow of Persis and their children at this moment of incalculable loss to the O & G community of our part of the world. All Sri Lankan colleagues of his, from the Sri Lanka College of O & G, are profoundly grieved and I, on behalf of all of them, wish him eternal bliss in whatever the way he yearned.

Dr. Hemantha Perera
President
Menopause Society of Sri Lanka and
Sri Lanka College of Obstetricians and Gynaecologists

Diyathalawa Workshop

The Menopause Society of Sri Lanka conducted its first clinical programme for 2012 in Diyathalawa. It consisted of two programmes. One for doctors and the other for all the health care workers. Doctors' programme was conducted at Sky Park Hotel, Diyathalawa on 15th January 2012. Dr. Hemantha Perera, Dr. M. D. P. Goonarathne and Dr. Piyusha Atapattu delivered lectures at this programme. The other programme was conducted on the following day at Base Hospital, Diyathalawa. There were 82 participants for the programme. Dr. Hemantha Perera, Dr. Mangala Dissanayaka, Dr. M. D. P. Goonarathne, Dr. Ananda Ranatunga, Dr. Piyusha Atapattu, Dr. Prasad Rannulu, Dr. Prasantha Gange, Dr. Chandina Wedamestri and Dr. Peshala Dangalla delivered lectures on this day.

Dr. Hemantha Perera, President, SLCOG and MSSL, delivering his lecture at the programme.

Dr. M. D. P. Goonarathne, Dr. Ananda Ranatunga and Dr. Hemantha Perera at the programme.

Dr. Ananda Ranatunga, Past President, SLCOG and MSSL, delivering his lecture.

Gampaha Workshop

The Menopause Society of Sri Lanka conducted a programme at GA office, Gampaha on 5th March 2012. There were 175 participants for this programme. Dr. Hemantha Perera, Dr. Mangala Dissanayaka, Dr. Rohana Haththtouwa, Dr. Sunil Fernando, Dr. M. A. K. Perera, Dr. S. P. Kandapala Arachchige, Dr. Asanka P. Rathnayaka, Dr. Prasad Rannulu and Dr. Peshala Dangalla delivered lectures for midwives and nurses at this programme. It was coordinated by Dr. Thilak Udayasiri, MOMCH - Gampaha

Dr. Rohana Haththtouwa delivering his lecture at the programme.

Dr. Hemantha Perera, President, SLCOG and MSSL, presenting a certificate to one of the participants.

A section of the participants.

Colombo Workshop

The Menopause Society of Sri Lanka conducted a programme at the S De S Jayasinghe Auditorium, Dehiwala on 30th April 2012. There were 147 participants for this programme. Dr. Hemantha Perera, Dr. M. D. P. Goonarathne, Dr. Rohana Haththtouwa, Dr. T. B. Dissanayaka, Dr. Mangala Dissanayaka, Dr. Prasad Rannulu, Dr. Prasantha Gange, Dr. Piyusha Atapattu and Dr. Sunera Fernando delivered lectures for midwives and nurses in this programme. It was coordinated by Dr. L. R. Liyanage, MOMCH, Colombo.

Dr. Prasad Rannulu delivering his lecture at the programme.

Dr. Sunera Fernando delivering her lecture at the programme.

Dr. Piyusha Atapattu delivering her lecture at the programme.

Hambantota Workshop

The Menopause Society of Sri Lanka conducted a programme at MOH office, Hambantota on 8th May 2012. There were 70 midwives and nurses for this programme. Dr. Hemantha Perera, Dr. M. D. P. Goonarathne, Dr. Mangala Dissanayaka, Dr. Prasantha Gange , Dr. Piyusha Atapattu, Dr. Harsha Atapattu, Dr. Manoj Perera, Dr. Mudhitha Gunasekera, Dr. Sumith Warnasuriya and Dr. M. M. P. Bandumithra delivered lectures for midwives and nurses in this programme. It was coordinated by Dr. R. P. S. Rajapaksha, MOMCH, Hambantota. Sri Lanka College of Obstetricians and Gynaecologists conducted a hands-on training programme for medical officers on emergency obstetrics parallel to this programme at Hambantota Hospital. This MO programme was organized by Dr. Manoj Perera, Consultant Obstetrician and Gynaecologist, Hambantota Hospital.

Dr. Hemantha Perera, President, SLCOG and MSSL, delivering his lecture at the programme.

Dr. Harsha Atapattu delivering his lecture at the programme.

Dr. Hemantha Perera, President, SLCOG and MSSL, presenting a certificate to one of the participants.

Kandy Workshop

The Menopause Society of Sri Lanka conducted a clinical programme at Kadugannawa Regional Health Training Centre on 28th May 2012. There were 104 midwives and nurses for this programme. Dr. Hemantha Perera, Dr. M. D. P. Goonarathne, Dr. Mangala Dissanayaka, Dr. Chathura Rathnayaka, Dr. Kumudini Jayasinghe, Dr. Sajeewa Rathnayaka, Dr. Sarada Kannangara and Dr Dewasmika Ariyasinghe delivered lectures for midwives and nurses in this programme. It was coordinated by Dr. Pramika Cooray, MOMCH, Kandy. Sri Lanka College of Obstetricians and Gynaecologists conducted a hands-on training programme for medical officers on emergency obstetrics parallel to this programme. This MO programme was organized by Dr. Kapila Gunawardena, Consultant Obstetrician & Gynaecologist, Teaching Hospital, Kandy.

Dr. Hemantha Perera, President, SLCOG and MSSL, Dr. M. D. P. Goonarathne and Dr. Nilani Fernando, Deputy RDHS, Kandy, lighting the traditional oil lamp.

Dr. Mangala Dissanayaka delivering his lecture.

Dr. Nilani Fernando presenting a certificate to a participant.

Ragama Workshop

The Menopause Society of Sri Lanka conducted a clinical programme at Teaching Hospital, Ragama on 30th May 2012. 104 midwives and nurses attended this programme. Dr. Hemantha Perera, Dr. M. D. P. Goonarathne, Dr. Sunil Fernando, Dr. Prasad Rannulu, Dr. Piyusha Atapattu, Dr. Lalin Fernando and Dr. Peshala Dangalla delivered lectures for midwives and nurses at this programme. It was coordinated by Dr. Sunil Fernando, Consultant Obstetrician and Gynaecologist and Dr. Prasad Rannulu, Consultant Obstetrician and Gynaecologist, Teaching Hospital Ragama.

Dr. Sunil Fernando delivering his lecture.

Dr. Piyusha Atapattu delivering her lecture.

Dr. M. D. P. Goonarathne, President, SAFOMS, presenting a certificate to a participant.

World Bank Site Visits

The Menopause Society of Sri Lanka visited estates in the Hatton region on 31st May 2012 to inspect the progress of the Training of Trainers (TOT) Programme implemented by the Society in collaboration with the World Bank of Sri Lanka in March 2012. Bambarakelle, Agarkanda, Craigie Lea, Mayfield, Kenilworth, Wanarajah, Battlegala, Ingestre, Glentilt and Venture were the estates inspected. Dr. Hemantha Perera, Dr. Mangala Dissanayaka, Dr. M. D. P. Goonarathne, Dr. Sunil Fernando, Dr. Sivagnanam Sivachandran and Dr. Singharathnam were resource personnel in this programme. Mr. Mervin Perera, Regional Director, PHDT, Ms. M. F. I. Farah, Manager Health, PHDT and Dr. Nihal Weerasuriya, MS-BH, Dickoya assisted the Menopause Society of Sri Lanka to make this programme a success.

Dr. Hemantha Perera, President, SLCOG and MSSL, being welcomed by the participants.

Dr. Nihal Weerasuriya actively participating in the workshop.

Dr. Sunil Fernando explaining a point to a participant.

Nuwaraeliya Workshop

The Menopause Society of Sri Lanka conducted a clinical programme at District General Hospital, Nuwaraeliya on 18th June 2012. 136 midwives and nurses attended this programme. Dr. Hemantha Perera, Dr. M. D. P. Goonarathne, Dr. Mangala Dissanayaka, Dr. Prasad Rannulu, Dr. Prasantha Gange, Dr. Lasantha Rajapaksha, Dr. Ajith Navaratne and Dr. Upul Vidanagama delivered lectures for midwives and nurses in this programme. It was coordinated by Dr. Lasantha Rajapaksha, Consultant Obstetrician and Gynaecologist, District General Hospital, Nuwaraeliya. Sri Lanka College of Obstetricians and Gynaecologists conducted a hands-on training programme for medical officers on Emergency Obstetrics parallel to this programme at RDHS office, Nuwaraeliya. This MO programme was organized by Dr. Thilina Wijethunga, MOMCH, Nuwaraeliya.

Dr. Hemantha Perera, President, SLCOG and MSSL, delivering his lecture at the programme.

Dr. Mangala Dissanayaka delivering his lecture.

Hands-on training for the participants.

Sri Jayawardenapura General Hospital Workshop

The Menopause Society of Sri Lanka conducted a clinical programme at Sri Jayawardenapura General Hospital on 22nd June 2012. There were 46 midwives and nurses for this programme. Dr. Hemantha Perera, Dr. M. D. P. Goonarathne, Dr. Jayanda Horadugoda, Dr. Madhava Karunarathne and Dr. Piyusha Atapattu delivered lectures for midwives and nurses in this programme. It was coordinated by Dr. Madhava Karunarathne, Consultant Obstetrician and Gynaecologist, Sri Jayawardenapura General Hospital.

Obesity after middle age

Post menopausal women are usually troubled by increasing weight and waist circumference. The pathophysiology and the deleterious health consequences of obesity and visceral fat deposition after middle age are discussed.

Normal fat tissue and obesity

Fat tissue is frequently the largest organ in the body. It has many functions including storing energy, thermoregulation, providing mechanical protection, and contributing to tissue regeneration and immune and endocrine function. Fat stores are necessary for survival during nutritionally depleted states such a starvation.

Obesity is the excess fat deposition in fat stores, which leads to many harmful effects. Obesity develops as a result of a complex interaction between many factors: eg. genetic influences, excessive caloric consumption, insufficient energy output, environmental effects. The pattern of distribution of excess fat rather than the actual increase in the total body fat stores has a greater impact on health with excess central fat deposition having a significant contribution to cardiovascular morbidity and mortality in postmenopausal women (Matvienko et al, 2011).

What happens to fat tissue after middle age?

Major changes in fat distribution and function occur throughout life (Tchkonia et al, 2010). Fat tissue mass increases though middle age and declines in old age. Fat is redistributed among different fat depots especially during and after middle age, from subcutaneous to intraabdominal visceral depots) causing an androidal fat distribution (Tchkonia et al, 2010). This results in an increase in abdominal circumference of 4 cm every 9 years in adult women (Koutsari et al, 2009). Moreover ectopic fat deposition in bone marrow, muscle, liver and other sites occur in old age.

Why should obesity be discouraged after middle age?

Obesity is a chronic low-grade inflammatory and prothrombotic state, with white adipose tissue releasing free fatty acids (FFA) and inflammatory adipokines including tumour necrosis factor (TNF), interleukin (IL)-1 and IL-6. Inflammatory adipokines play a central role in the pathophysiology of metabolicsyndrome,diabetes mellitus, insulin resistance, dsylipidaemia, hypertension, atherosclerosis, non-alcoholic steatohepatitis and other co-morbidities such as malignancies (Redinger, 2007).

Different fat depots make different contribution to proinflammatory and clinical consequences of obesity, with visceral fat having the strongest association with obesity related disorders. Thus obesity after middle age, where there is a relative increase in the visceral fat in the abdominal fat depots, makes a significant contribution to morbidity and mortality after middle age.

Dr. P. M. Atapattu
Senior Lecturer in Physiology
Faculty of Medicine,
University of Colombo

What should be done regarding obesity?

The main aspects of obesity management are diet control and physical exercise. Weight reduction improves all aspects of metabolic syndrome and all-cause and cardiovascular mortality.

Walking or light jogging for one hour daily will produce significant loss of visceral fat, leading to cardiovascular risk reduction. The aim is to lose 10% of basal weight in 6-12 months, until the target body mass index is reached and to maintain a waist circumference <80 cm in women (Rao, 2008).

Medical management with drugs (orlistat), and surgical approaches with bariatric surgery have been found to be effective in morbid obesity (Rucker et al, 2007 Sjöström et al, 2007).

Table 1. Substances released by adipocytes contributing to obesity-related morbidity

Adipokine promotors	
Inflammatory	IL-1, IL-6, TNF-a, IFN-a, IFN-b, IL-8. IP-10, TGF-b, MCP-1, leptin, resistin
Insulin resistance	TNF-a, IL-6, resistin
Procoagulant	PAI-I, tissue factor, TNF-a, IL-6, TGF-b
Angiogenetic	Leptin, IL-8, VEGF, FGF-2, MCP-1, IP-10, VCAM, ICAM, monobutyrin
Lipogenetic (adipogenesis)	IGF-1, angiotensinogen, angiotensin II, visfatin, acylation-stimulating protein

Management goals for obesity

- Weight reduction - 10% of basal weight in 6-12 months
- Physical exercise - 30-40minutes/day on 3-5 days/week
- Dietary changes - reduced calories, fat and carbohydrate
- BMI - <23kg/m^2
- Waist circumference - <80 cm

Behavioural Change for Lifestyle Modification

Introduction

Getting the right balance between work and home life, recreational interests and personal health can be very difficult. Health needs rarely make it to the top of the list of competing demands until something goes wrong, Sometimes a person may be so busy that by the time a warning signal occurs (physical illness or high blood pressure) the harm may already be irreparable. Therefore it is important to give health priority. Behaviour change is useful for introducing healthy lifestyle changes such as eating a healthy diet and exercising regularly which are important during and after menopause to ensure good health.

Changing behaviour is all about motivating people to see the benefit of change and then taking action to implement those changes. This is important when making lifestyle modifications during menopause to adjust to changes in their lives (with ageing) or think about changing their behaviour for example, giving up smoking, and adopting a healthy lifestyle with exercise. In these situations motivation is the key factor and this helps people to make decisions taking into account their circumstances and their goals.

Steps in Behaviour change

The first step is to motivate the patient by bringing out reasons for why behaviour change is needed. This can be done by showing the discrepancy between the patient's current behaviour (not exercising) and the need the patient has to reduce weight and become healthy. The patient should be helped to identify these discrepancies between their goals and how their present behaviour will need to be changed to achieve these goals.

Dr. Sunera M. Fernando

Consultant Psychiatrist, University Psychiatry Unit, NHSL and Department of Psychological Medicine, Faculty of Medicine, University of Colombo.

Assessing your lifestyle

- Are you getting at least 20 minutes of exercise three times a week?
- Are you eating a nutritious balanced diet?
- Do you need a medical checkup?
- Are you spending time on activities that you don't need to be doing?
- Are you stressed?

Steps in behaviour change

- Motivating the patient
- Educating the patient
- Identifying goals
- Identifying factors that maintain current behaviour
- Identifying strategies to change behaviour
- Involving family members
- Monitor progress

Identifying goals for behaviour change

People are usually goal directed. Setting and working towards goals increases motivation and releases a large amount of energy to help behaviour change. The goals need to be written down because writing makes it be there for a person to see and increases commitment to achieve the goal. The goals have to be specific and measurable. They need to be practical, have a timeframe and have an outcome. For example, "By next month I will be brisk walking for half an hour a day for five days of the week" or "From this week I will eat at least one portion of fruit a day and not take sweets/chocolates". If one goal is too difficult to achieve it can be broken down into smaller manageable ones. For example "By next month I will exercise for 20 minutes a day at least one day a week" and then "In two months time I will exercise 20 minutes a day thrice a week".

Identifying factors that maintain present behaviour

The present unhealthy lifestyles may be maintained by certain factors and these need to be identified before behaviour change. It is only when the patient is aware of the reasons that they maintain their unhealthy behaviour patterns that they can begin to change their behaviour. For example, the present behaviour of not eating fruits and vegetables may be maintained by the fact that it is easy for patient to buy fast food or snacks, or because it is difficult and expensive to buy fresh fruit.

Features of Goals:

- Specific
- Have a time frame
- Objective
- Practical
- Achievable

Identifying obstacles to behaviour change

When behaviour change is done there may be barriers/ obstacles to this change which need to be identified and dealt with to sustain the change. For example when starting regular exercise the patient may say that they do not have time for exercise during the day. This should then be discussed and the patient advised to use time management strategies to make half an hour available for physical exercise. They may say they cannot exercise in bad weather. In this situation alternative locations such as long indoor corridors can be used for brisk walking.

Effective motivational approaches

- Giving advice
- Removing barriers
- Providing choice
- Decreasing desirability of old behaviour
- Providing feedback
- Clarifying goals

Identifying strategies for behaviour change

The strategies for implementing the new behaviour must be identified and written down by the patient with the aim of meeting the goal that was set. An example is: for the goal "By next month I will be brisk walking for half an hour a day for five days of the week", the strategies could be:

- Go for a walk every evening for 30 minutes before going home after work
- Wake up half an hour early in the morning and go for a walk in the morning for 30 minutes.

It is important that family members are involved in the behaviour change. Therefore in this situation it would be good if a family member can also join the person and do this exercise with them.

When implementing a healthy diet with fruits and vegetable the family members can also eat healthily and make sure the marketing is done in accordance with the healthy diet and no junk food is brought to the house. In this way not only the patient but the whole family will benefit from this healthy diet.

It is important to get family members involved in the behaviour change programme.

Monitor progress and achievement of goals

The goal and how far the person has achieved it has to be monitored so that the person can be supported in their behaviour change. This would be done by checking how the persons have adhered to the new behaviour. Any problems they have encountered need to be discussed and strategies identified to overcome them.

Work out a reward system

Once the goal is reached let the patient give himself a reward. The reward has to be identified beforehand. This reward has a role of motivating behaviour change. Always help the patient to visualize the end result when they achieve behaviour change. This helps with sustaining motivation.

Once a behavioural goal is achieved the person must give himself/herself a reward

Summary / key points

Changing behaviour is motivating people to see the benefit of change and then taking action to implement those changes with regard to adopting a healthy lifestyle with diet and exercise.

It is necessary to set specific goals for behavioural change and monitor how these are achieved.

Family members should also be involved in the behaviour change programme.

History of the Menopause Society of Sri Lanka

Introduction

- The Menopause Society of Sri Lanka was started 12 Years ago (on 19th June 2000 at 8pm at Library Hall, Castle Street Hospital for Women)
- Founder/President - Dr. M D P Goonarathne and Founder/ Secretary Dr.Hemantha Perera

  Successive Presidents - Dr.Rohan Perera, Prof. W. I. Amarasinghe, Dr. Ananda Ranatunga, Dr. Kolitha Sellahewa
- Current President - Dr. Hemantha Perera and Current Secretary - Dr. Mangala Dissanayaka
- Objective - "committed to improve the post reproductive life of Sri Lankan women"

Local programmes conducted

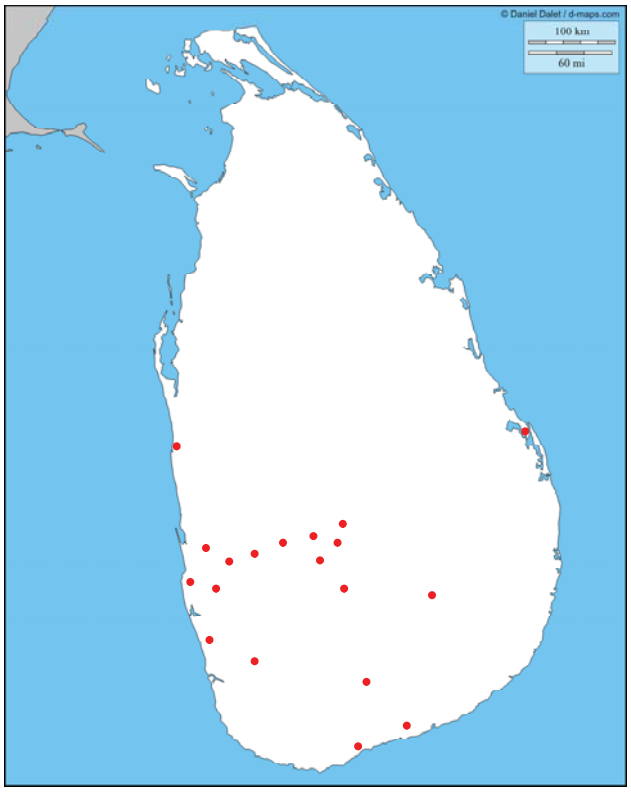
We have Conducted more than 20 programmes on current management of post reproductive health for health care workers during the last two years in different areas of Sri Lanka.

i. Hospital meetings conducted for midwives

Year 2010
Sri Jayawardenapura General Hospital

Year 2011
De Zoysa Maternity Hospital, Castle Street Hospital for Women, Karawanella Base Hospital Embilipitiya Base Hospital, Batticaloa Teaching Hospital, Chilaw General Hospital

Year 2012
Diyathalawa Base Hospital and District General Hospital, Nuwaraeliya



ii. Clinical programmes conducted in the field for health care workers

Year 2010
Tangalle programme at MOH office

Year 2011
Panadura and Agalawatta programme at MOH office

Year 2012
Matara programme at Samupakara Mandiraya, Gampaha programme at GA office,

Colombo programme at S.De.S.Jayasinghe Auditorium, Hambantota programme at MOH office

Kandy programme at Kadugannawa regional health training centre

We have trained about 2500 midwives and nurses during these two years

iii. We are conducting a project in Estate Sector in collaboration with the World Bank of Sri Lanka and Plantation Human Development Trust. Initially Training of Trainers programme (TOT) was implemented to update the knowledge of midwives in the estate sector about menopause related issues. Those trained midwives were used to train a team of volunteers. Both the midwives and volunteers were given handbooks for further reading. We carried out an inspection on 31st May 2012 to review the progress of the programme and it was perceived that this programme was a real success. The next follow- up programme is scheduled on 29th July 2012.

Programmes conducted for Doctors and Medical students during the last two years.

Year 2011
Diyathalawa programme for doctors at Sky Park Hotel, Diyathalawa

Year 2012
EMA programme in Hatton and Kandy Medical Student programme

Representation of the Menopause Society of Sri Lanka, in other societies

i. We conducted the inaugural SAFOMS meeting in 2010 in Colombo

ii. Symposium conducted in 124th Annual Scientific Sessions of the Sri Lanka Medical Association (SLMA)

iii. Symposiums conducted in Satellite programmes of SLMA

iv. Representation in International conferences.

Other Activities

i. A News letter is issued once in 3 months

ii. Continuous education of the public is done through paper articles and web facilities

iii. Preparation of teaching modules to Medical students, Nurses and MOHS

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