Foreword

One of the main objectives highlighted in our 2017 – 2020 national strategic health plan is the achievement of the best possible outcomes from health care services, within this framework, the Palestinian Ministry of Health (MOH) has been working towards developing unified protocols.

The Ministry of Health has worked through various administrations and within the framework of the Palestinian Ministry of Health policy and under the guidance of the Minister of Health, Dr. Mai Al-Kila, the Director General of Public Health, Dr. Yasser Bouzieh, and the Director-General of Primary Health Care, Dr. Kamal Al-Shakrah.

I would like to thank General Directorate of Public Health (Community Health Department), I would like to thank all participants stakeholders for their efforts and contributions in this great work, special thanks are extend to UNFPA for their continued support to the Palestinian health system.

To produce this menopause guideline with our strong belief in the importance and necessity of unity the services provided to this group of women and our awareness of the importance of working to improve the quality of life because of the difference at all levels of health, psychological, social and economic.

We also extend our sincere thanks and appreciation to the members of the National Committee who have not hesitated in their efforts to accomplish this joint work.

I also thank UNFPA (United Nation Population Fund) for the continues support to the Ministry of Health in the accomplishing women’s health programs.
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Abbreviations :

BMI : Body Mass Index
CBT : Cognitive Behavioral Therapy
CVD : Cardiovascular Disease
DEXA : Dual-energy x-ray absorptiometry
DVT : Deep Vein Thrombosis
FBE : Full Blood Examination
FBG : Fasting Blood Glucose
HRT : Hormone Replacement Therapy
OBG : Obstetrics and Gynecology Guideline
PE : Pulmonary Embolism
TSH : Thyrotropin Stimulating Hormone
UTIs : Urinary tract infections
VTE : Venous Thromboembolism
Introduction

The production of menopauses guideline has been prepared for the health providers in the clinic for facilitating and unification of all activates, this guideline considered the first of its kind in the field of health services provided to women in menopause period, is a belief in the importance of standardizing and applying the scientific standards offered to this important category of women.

The implementation of this guide will contribute to improving the quality of life of women in this category. the production of this guide comes as a result of joint efforts of the Committee formed for this purpose, which represented all health sectors in Palestine (governmental, non-governmental, UNRWA, NGOs, private sector ……..)

Purpose

To streamline the care pathway and services for women who present with menopausal symptoms.

Background and definitions:

Menopause is a biological stage in a woman’s life that occurs when she stops menstruating and reaches the end of her natural reproductive life.

Usually it is defined as having occurred when a woman has not had a period for 12 consecutive months (for women reaching menopause naturally).

The changes associated with menopause occur when the ovaries stop maturing eggs and secreting oestrogen and progesterone.

*between 45 – 55 years
Menopausal women:
This includes women in perimenopause and post menopause.

Perimenopause:
The time in which a woman has irregular cycles of ovulation and menstruation leading up to menopause and continuing until 12 months after her final period is also known as the menopausal transition or climacteric.

Post menopause, is the time after menopause has occurred, starting when a woman has not had a period for 12 consecutive months.

Premature menopause, also called: {premature ovarian insufficiency}or{premature ovarian failure}, is usually defined as menopause occurring before the age of 40 years.
Symptoms of Menopause:

Vasomotor symptoms (hot flushes and night sweats) are the most commonly reported symptoms, occurring in about 75% of postmenopausal women, with 25% of these being severely affected. Symptoms may resolve in 2–5 years, but the median duration is 7 years and sometimes longer, they may also occur during perimenopause.

Other symptoms include mood changes, musculoskeletal symptoms, urogenital symptoms, sleep disturbance, and sexual disorders (Table 1)

*Tabel 1. Symptoms of Menopause

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>AND / OR</th>
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<tr>
<td>*Irregular bleeding</td>
<td>*Dyspareunia</td>
<td>*Osteoporosis</td>
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<td>*Anxiety</td>
<td>*Vaginal dryness</td>
<td>*Cardiovascular risk</td>
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<td>*Vasomotor</td>
<td>*Poor sleep</td>
<td>*Dementia</td>
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<tr>
<td>-Hot flushes</td>
<td>*No interest in sex</td>
<td>*Diabetes</td>
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<td>-Night sweats</td>
<td>*Joint pain</td>
<td>*Obesity</td>
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<td>*Recurrent UTIs</td>
<td>*Central weight gain</td>
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Risk of chronic disease after menopause

*Women with untreated premature menopause and early perimenopause* (menopause between the ages of 40 and 45 years) are at increased risk of mortality and serious morbidity, including cardiovascular disease (CVD), cognitive decline, dementia, parkinsonism, and osteoporosis. This increased risk is due to the menopausal decrease in oestrogen levels.

*Postmenopausal women* are at increased risk of osteoporosis, CVD, stroke, atrophic changes in the vagina and bladder, due to oestrogen depletion as well as natural ageing.
Diagnosing Menopause

Diagnose the following without laboratory tests in otherwise healthy women aged over 45 years with menopausal symptoms (Table 1):

- A. Perimenopause if the woman has vasomotor symptoms and irregular periods
- B. Menopause if the woman has not had a period for at least 12 months
- C. Menopause based on symptoms in women without a uterus

Consider using the follicle stimulating hormone (FSH) blood test to diagnose menopause in the following groups of women provided they are not taking combined oestrogen and progestogen contraception or high-dose progestogen, as the diagnostic accuracy of the FSH blood test may be confounded by these treatments:

- Women aged over 45 years with atypical symptoms
- Women between 40–45 years with menopausal symptoms, including a change in their menstrual cycle
- Women younger than 40 years in whom premature menopause is suspected

Diagnosing Premature Menopause

The diagnosis of premature menopause should take into account the woman’s clinical history (for example previous medical or surgical treatment) and family history.

A. Diagnose premature menopause in women younger than 40 years based on:

- Menopausal symptoms, including no or infrequent periods (taking into account whether the woman has a uterus) and
- Elevated follicle stimulating hormone (FSH) levels on 2 blood samples taken 4–6 weeks apart. Do not use a serum FSH test to diagnose menopause in women using combined oestrogen and progestogen contraception or high-dose progestogen, as the diagnostic accuracy may be confounded by these treatments.

B. If there is doubt about the diagnosis of premature menopause, consider anti-Müllerian hormone testing after seeking specialist advice.

- Do not diagnose premature menopause on the basis of a single blood test
Examination:

- Height and weight (BMI).
- Blood pressure and cardiovascular system.
- Pelvic examination (+/- Pap Smear).
- Breast exam.
- Thyroid examination.

Midlife Women (50 yrs) health assessment:

- Pap Smear
- Mammogram
- Lipids
- FBG
- TSH
- Renal and liver function
- Vit D and calcium level in at risk women.
Diagnosis of perimenopause

Post-hysterectomy

*Vasomotor symptoms

Uterus present

Amenorrhea for more than 3 month
and vasomotor symptoms

Exclude pregnancy serum pregnancy test

Positive

Age 40 – 45 years

*FSH

>25mIU/ml

5-25mIU/ml

Negative

Age ≥45 years

- Monitor BP
- FBS, triglycerides, HDL, LDL
- Vit D and calcium level
- BMI
- Estrogen level

Normal

Abnormal

Perimenopause

Refer/treat accordingly

Refer to gynecologist
Assessment of menopause

Assess her symptoms and their severity. This helps determine:

- The most suitable treatment (hormonal, non-hormonal, or non-pharmacological).
- The severity of the symptoms and the extent to which they are affecting the woman’s quality of life.

Assess her risk of cardiovascular disease (CVD):

- Women with, or at increased risk of, CVD should have their cardiovascular risk factors managed.

Assess her risk of osteoporosis:

- Discuss the woman’s expectations:
- Ask why she has consulted (for example concern regarding the cause of the symptoms).
- Ask if she would like treatment for her symptoms.
- Consider doing DEXA scan for patients found to be at high risk of osteoporosis and osteopenia.

Information and advice:

- An explanation of the stages of menopause.
- The common symptoms of the menopause.
- Available treatments for menopausal symptoms, including hormone replacement therapy (HRT), non-hormonal treatments (such as antidepressants), and no pharmacological treatments (such as cognitive behavioral therapy [CBT] and relaxation techniques).
- The risks possible adverse effects, benefits, and expected duration of treatment with HRT.
- Advice on contraception, including that HRT does not provide contraception and that a woman is considered potentially fertile for 2 years after her last menstrual period if she is younger than 50 years of age, and for 1 year if she is over 50 years of age.
- Give advice on lifestyle modifications to reduce menopausal symptoms.
- For example:
  - Hot flushes and night sweats: regular exercise, weight loss (if applicable), wearing lighter clothing, sleeping in a cooler room, reducing stress, and avoid-
ing possible triggers (such as spicy foods, caffeine, smoking, and alcohol).

- Sleep disturbances — avoiding exercise late in the day and maintaining a regular bedtime.
- Mood and anxiety disturbances — adequate sleep, regular physical activity, and relaxation exercises.
- Cognitive symptoms — exercise and good sleep hygiene.

Management of menopause:
Managing the menopause without HRT

- Advise on lifestyle modification to reduce menopausal symptoms.
- If lifestyle modifications are ineffective, consider one of the following:
  * Prescribe non-hormonal and/or non-pharmacological treatments for symptom relief:
    - For vaginal dryness, prescribe a vaginal lubricant or moisturizer
    - For sexual dysfunction, seek specialist advice regarding the use of testosterone supplementation (off-label use). Obtain (and document) informed consent before prescribing testosterone for this indication.
    - For psychological symptoms, such as mood disturbance, anxiety, and depression, consider self-help groups, cognitive behavioral therapy (CBT), or antidepressants. Note that there is no clear evidence for antidepressants to ease low mood in menopausal women who have not been diagnosed with depression.
    - Refer the woman to a healthcare professional with expertise in menopause.
    - Advise the woman to return if her symptoms persist or worsen.
    - For women considering complementary therapies, explain that the quality, purity, and constituents of these products may be unknown.
    - Although there is some evidence that is flavones and black cohosh may relieve vasomotor symptoms, their safety is unknown and different preparations may vary

*Review the woman* at 3 months, then annually thereafter unless there are clinical indications for an earlier review (such as treatment ineffectiveness or adverse effects). At the review:

- Assess efficacy and tolerability of treatment(s).
- Reinforce information and lifestyle advice.
- The use of vaginal moisturizers and lubricants may be continued indefinitely.
Managing the menopause with HRT

(should be authorized by specialist OBG)

If a woman chooses to use hormone replacement therapy (HRT), following a discussion on the risks, possible adverse effects, and benefits, and there are no contraindications to its use:

* Advise on lifestyle modifications to reduce menopausal symptoms.
* Prescribe the most suitable type of HRT based on her symptoms:

Ø For vasomotor symptoms:

In woman with a uterus, offer an oral or transdermal combined (oestradiol plus-progestogen) HRT preparation.

In women without a uterus, offer an oral or transdermal oestrogen-only preparation.

In women diagnosed with premature menopause, offer sex steroid replacement with a choice of HRT or a combined oral contraceptive (unless contraindicated). For effects on mood, offer a choice of oral or transdermal HRT preparations as above.

Consider referring the woman for a trial of cognitive behavioural therapy (CBT) to alleviate low mood and anxiety.

*For urogenital symptoms, manage according to the specific symptom:

- For women with urogenital atrophy (including those already using systemic HRT), offer low-dose vaginal oestrogen. Continue treatment for as long as needed to relieve symptoms.
- For women with vaginal dryness, advise that moisturisers and lubricants can be used alone or in addition to vaginal oestrogen.

*For sexual dysfunction, seek specialist advice regarding the use of testosterone supplementation (off-label use). Obtain (and document) informed consent before prescribing testosterone for this indication.

*For women considering complementary therapies, explain that the quality, purity, and constituents of these products may be unknown.

Although there is some evidence that is flavones and black cohosh may relieve vasomotor symptoms, their safety is unknown and different preparations may vary.

*Advise women with premature menopause that they should not use HRT as contraceptive..
**Review the woman** at 3 months, then annually thereafter unless there are clinical indications for an earlier review (such as treatment ineffectiveness or adverse effects). At the review:

- Assess efficacy and tolerability of treatment(s). If low-dose vaginal oestrogen does not relieve symptoms, consider increasing the dose after seeking specialist advice from a healthcare professional with expertise in menopause.
- Reinforce information and lifestyle advice
- If HRT was started in the perimenopause, discuss the option of changing the treatment regimen and/or reducing the dose of oestrogen in the HRT (with longer duration of treatment).
- Be aware that HRT may need to be stopped immediately in certain circumstances.

**Consider referring the woman to a healthcare professional with expertise in menopause if:**

- Treatment is ineffective.
- They have ongoing troublesome adverse effects.
- There are ‘red flag’ symptoms such as unexplained bleeding or a gynecological cancer is suspected.

*For vasomotor symptoms*, most women require 2–5 years of HRT, but some women may need longer. This judgement should be made on a case-by-case basis with regular attempts to discontinue treatment. Symptoms may recur for a short time after stopping HRT.

*Topical (vaginal) oestrogen* may be required long term. Regular attempts (at least annually) to stop treatment are usually made. Symptoms may recur once treatment has stopped.

*Women with premature menopause* usually take HRT up to the average age of the natural menopause (51 years), after which the need for HRT should be reassessed. Some women will still be symptomatic.

*Offer women who wish to stop HRT a choice of gradually reducing or immediately stopping treatment*

- Gradually reducing or immediately stopping HRT makes no difference to their symptoms in the longer term.
- Gradually reducing HRT may limit recurrence of symptoms in the short-term.
• Symptoms of urogenital atrophy often come back when treatment with vaginal oestrogen is stopped.

**Women with or at high risk of breast cancer:**

For advice on the treatment of menopausal symptoms in women with breast cancer or at high risk of breast cancer.

Offer menopausal women with or at high risk of breast cancer:

• Information on all available treatment options.

• Referral to a healthcare professional with expertise in menopause.

**Types of treatment for menopausal symptoms:**

**Cognitive behaviour therapy**

CBT is a psychosocial intervention to improve mental health and help people to develop practical ways of managing problems and provides new coping skills and useful strategies. For this reason, it can be a helpful approach to try because the skills can be applied to different problems, and can improve wellbeing in general.

**Hot flushes and night sweats**

Hot flushes and night sweats are the main changes experienced by women during the menopause transition – the time when menstrual periods stop. Flushes can be accompanied by sweating, and palpitations or sometimes shivering, and can cause embarrassment, anxiety, discomfort and sleep disruption.

Cognitive behaviour therapy can help women who suffer from hot flashes to Calm down as follow:

1. What can help to cool down? Wear light layers so it is easy to remove layers if you have a hot flush. Try wearing loose fitting clothes made of natural, light fabrics such as cotton. Cotton sheets, with a lower thread count, will also help you to remain cool at night. Remove any heavy, thick down duvets from your bed; placing a towel in your bed can absorb some of the sweat, preventing your sheets from becoming drenched. Some women also use a Chillow Pillow, which remains cool throughout the night.
2. Hot flushes can be triggered by stimulants, such as coffee, hot drinks and some spicy foods, alcohol, stress, by changes in temperature, or activities, e.g. rushing to work. If you keep a diary of hot flushes and note down what was happening just before the flush you might be able to identify your hot flush triggers, and then by making small practical changes you can gain some control over them.

3. Relaxation and paced breathing can be used to calm down your body’s physical and emotional reactions. Paced breathing is slow, even breathing from your stomach. The diaphragm is located just below the lungs and forms a barrier between the lungs and the stomach. Breathing from the stomach or below the diaphragm increases lung capacity, so that we get more oxygen, and it also has a significant calming effect. If practiced regularly, paced or diaphragmatic breathing can help you to relax. You can practice by keeping the chest and shoulders still and pushing the stomach out as you breathe in, and taking slow, deeper breaths. Putting one hand on your chest and one hand on your stomach helps as you get used to this way of breathing. The hand on your chest should stay fairly still and the hand on your stomach should rise and fall as you breathe. It might be easier to practice this lying down at first. Once you get used to it you will be able to use this breathing for a few minutes during the day to reduce stress and to feel calm. Let your shoulders relax and focus on your breathing for a few minutes can give you time to pause and to think how you want to react in a stressful situation.

Cognitive and behavioural strategies for hot flushes and night sweats

**Paced breathing** is an important part of the CBT approach for hot flushes. As with any skill it requires regular practice – breathing from your stomach. At the onset of a flush – relax your shoulders – breathe slowly from your stomach – concentrate on your breathing. Paced breathing involves focusing on your breathing, accepting that the hot flush will pass and just letting the hot flush flow over you.

**Cognitive (thinking) strategies** – women’s main types of worries about hot flushes and night sweats tend to be:

1. Social embarrassment (especially around men, younger people and at work) – “Everyone’s looking at me” – “I look terrible”.
2. Lack of control – “This is out of control”, “I can’t cope with these”, “not again!”
3. Worries about disrupted sleep – “I’ll never get back to sleep”, “I’ll feel terrible tomorrow”.

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The diaphragm is located just below the lungs and forms a barrier between the lungs and the stomach. Breathing from the stomach or below the diaphragm increases lung capacity, so that we get more oxygen, and it also has a significant calming effect.
Anxiety and stress

Anxiety and stress are common reactions to everyday life. The menopause is not necessarily a stressful time but it occurs during midlife when you may be dealing with other life challenges, such as parents’ ill-health or bereavement, adolescent children, children leaving home (or not leaving home), or work demands. Having hot flushes and night sweats can also be stressful, and being anxious and stressed can make hot flushes more difficult to deal with.

Cognitive and behavioural strategies for anxiety and stress

Cognitive and behavioural strategies can be used to develop a calmer or accepting view of a situation and therefore to respond (behave) in a helpful way. If you feel anxious or stressed write down your thoughts, feelings and behavioural reactions on the diagram. Once you have identified a typical anxious thought, consider whether it is overly negative, overestimating the threat or underestimating your ability to cope. Remember – anxious/stressful thoughts are not facts but are just one view of a situation. Ask yourself: Is there really a threat? What would a calm person think in this situation? What would you say to a close friend if they were in this situation? Have I managed similar situations before?

Check your behavioural responses to anxiety and stress and if you are over-working, eating/drinking too much, or avoiding certain people or activities, then consider more helpful alternatives. Think about what you do that makes you feel calm or content, however small those things might be (e.g. relaxing, yoga, going for a walk, exercise, calling a friend, reading a book). Try to do more of these activities even for just a short time every day. Aim for a balance between rest and activity, and by pacing activities throughout the day.

Low Mood

Low Mood should not be expected during the menopause, and many women are relieved not to have periods. But it can occur at this time for a variety of reasons. For example, hot flushes and night sweats can be tiring and affect sleep; self-esteem can be affected by overly negative beliefs about menopause, and overly negative expectations about aging; and busy lifestyles and demands often accumulate during mid-life. Some women report premenstrual type symptoms, which may be associated with fluctuating hormones. Most of these factors are time limited and after the menopause in general women tend to report increased wellbeing compared to when they were in their 40s.
Cognitive and behavioural strategies for low mood

Cognitive and behavioural strategies can help people to make changes so that they begin to increase activity and be less self-critical. The first step is to look at life from a broad perspective – the things that you value (about yourself and life in general), what you used to enjoy doing, and/or how you would like things to be in 5 years time. Then you could gradually reengage in activities that you previously valued and enjoyed but which you might have dropped or withdrawn from since feeling low. Making these changes in behaviour by engaging in pleasant activities and developing a structure to the day can help to initially lift mood.

As with anxiety and stress – remember that depressive thoughts are not facts but are just one view of a situation. Ask yourself: Is this view of myself really accurate? What would a close friend/family member say to me? What would a self-supportive alternative be? For example, instead of ‘I’m not good enough’, ask yourself who is saying this and what is the evidence – we are usually harder on ourselves that we need be. Talking to other people can help to gain a helpful perspective. Small changes such as gradually doing things that you have enjoyed, or new things, and writing down three things that went well at the end of each day (however small) can lift mood and improve wellbeing. An important part of CBT is to encourage people to value their own qualities, strengths and competencies. If problems are persistent, e.g. financial, health, housing etc, then ‘problem-solve’ considering all options with someone else, and seek practical help and advice.

Night sweats and sleep problems

Night sweats and sleep problems can be particularly challenging to deal with given the negative impact that night sweats can have on sleep. Research studies with women going through the menopause have found that worrying at night about sleeplessness and its effects on the following day (tiredness, wellbeing and performance) can lead to anxiety which then makes sleep less likely. Therefore, managing sleep and night sweats requires a two pronged approach:

1. creating good habits to optimise sleep behaviour and environment, and
2. applying the cognitive behavioural work for hot flushes to develop calmer thinking and behavioural responses when sleep is disrupted due to night sweats.

The following changes can help to improve sleep quality when practised consistently over time, as they train your body’s natural rhythms to facilitate sleep:

- Limiting light in the early evening and in the bedroom helps the brain to release chemicals (melatonin) linked to sleep onset. This includes light emitted from mobile phones and laptops so switch these off.
• Limiting caffeine and alcohol, both of which have a negative impact on sleep onset and quality.
• A cool sleeping environment helps facilitate sleep as the body naturally cools as we sleep. This is particularly important when you are having night sweats.
• Develop a good bedtime wind-down routine that you practise each night to help you relax prior to going to bed which makes sleep more likely.
• Maintain a regular sleep pattern – ‘lie-ins’ and naps after 3 p.m. eat into sleep the following night which means you could have difficulty dropping off. It is best to avoid naps all together is possible, but if you really need one, make sure its before 3pm.
• Even after a poor night sleep, research consistently shows that it is better to continue as planned the next day and not cancel activities and plans, as this can set up unhelpful thinking and behaviour that makes sleep problems worse.

Life styles modification and Exercise

The general advice to eat a healthy, varied diet, based on starchy foods and plenty of fruit and vegetables, and low in saturated fat, sugar and salt, applies to women of all ages regardless of their life-stage. You can find more information on eating healthily here.

For menopausal and post-menopausal women there are aspects of the diet that are especially important, in order to reduce the risk of developing cardiovascular disease and osteoporosis and to help with day-to-day menopausal symptoms associated with lower levels of oestrogen.

• Eat a healthy and balanced diet
• Follow a heart healthy diet
• Maintain a healthy weight
• Meet your calcium and vitamin D needs

Calcium

The recommended intake of calcium is 700 mg per day for adults. You should be able to get all the calcium you need from your diet. Important sources of calcium are:

• dairy products, such as milk, yogurt or cheese (go for the lower fat options);
• products fortified with calcium, such as bread (most bread flour is fortified with calcium), breakfast cereals and dairy alternatives (e.g. soya drinks);
- some green leafy vegetables such as watercress and kale (but not spinach);
- sesame seeds;
- dried figs;
- and fish that is eaten with bones (such as sardines).

**Vitamin D**

Vitamin D is also important for bone health as it helps the absorption of calcium from foods. Vitamin D is produced in our skin when we are exposed to sunlight.

Between April and September, you will usually get sufficient amounts of vitamin D from exposure to sunlight through time spent outdoors and from dietary sources. Between October and March, the sunlight is not strong enough to produce vitamin D in our skin and we have to rely on dietary sources. Important dietary vitamin D sources are:
- oily fish;
- eggs;
- red meat;
- and foods fortified with vitamin D by the manufacturer, such as fat spreads, breakfast cereals and dairy products.

As vitamin D is found in only a small number of foods, it might be difficult to get enough from foods that naturally contain vitamin D and/or fortified foods alone. So it is recommended that everyone takes a daily supplement containing 10 μg of vitamin D during this period. People who have limited exposure to the sun (e.g. those who cover their skin or stay indoors most of the time) and those from ethnic minority groups with dark skin are recommended to take a daily supplement containing 10 μg of vitamin D all year round as they are at an increased risk of vitamin D deficiency.

For women at risk of osteoporosis, high intakes of vitamin A may have a negative effect on bone health. If you regularly eat liver and liver products you should avoid taking supplements containing more than 1.5 mg of vitamin A per day. Watch out for fish liver oil supplements as they are also often high in vitamin A.

**Diet and heart health**

Women who are post-menopausal have an increased risk of cardiovascular disease and so it is important to make sure you are eating foods that help to protect your heart.

Top dietary tips for a healthy heart include:
- Cut down on saturated fat and replace with unsaturated fats – for example swap butter and coconut oil for rapeseed, olive and sunflower oils and spreads made from these.
- Have fish twice a week – once should be an oily type (such as mackerel, salmon or sardines).
- Watch your salt intake – aim for less than 6 g a day. Check the nutrition label on foods and don’t add salt in cooking or at the table.
- Include high-fibre and wholegrain foods in your diet, such as wholegrain breakfast cereals, wholewheat pasta and pulses (e.g. lentils and beans). Fruit and vegetables are good fibre providers too.
- Don’t drink alcohol to excess – adults should drink no more than 14 units a week, with several alcohol-free days each week.
- Quit smoking to reduce the risk of having cardiovascular events.

**Nutrition**

It is important to maintain a healthful and varied diet when managing the bodily effects of menopause.

Researchers found that omega-3 may ease psychological distress and depressive symptoms.

Omega-3 is available in foods such as oily fish. Supplements are also available.

Women experiencing menopause should eat a well-balanced diet that includes:
- vegetables
- fruits
- whole grains
- unsaturated fats
- fiber
- unrefined carbohydrates

Try to consume between 1,200 and 1,500 milligrams (mg) of calcium and plenty of vitamin D each day.

**Exercise**

Exercise during menopause can have a range of benefits, including preventing weight gain, reducing cancer risk, protecting the bones, and boosting general mood.

Pilates, for example, has shown great benefit in reducing all menopausal symptoms not related to the urinary system and genitals, including sleep problems and hot flashes.
Women should exercise earlier in the day during menopause to avoid causing any interruptions to their sleep cycle.

Kegel exercises can be useful for preventing urinary incontinence. These are exercises to strengthen the pelvic floor. Practicing 3 or 4 times a day can lead to a noticeable improvement in symptoms within months.
Menopause Guideline

**The Bridge**
1. Lie on your back, knees bent and feet flat on the floor, hip-width apart
2. Inhale and squeeze and lift your pelvic floor
3. Lift your hips & Hold up to 10 seconds
4. Lower your hips and release your pelvic floor

**The Wall Squat**
1. Stand against a wall, feet hip-width apart
2. Inhale, squeeze and lift your pelvic floor, and lower yourself into a squat
3. Hold for 10 seconds
4. Rise back up to standing and release your pelvic floor
5. Rest for 10 seconds

For a more targeted approach, it's crucial that you focus on your Kegel muscles exclusively. You might find it difficult at first, especially if you have a weakened pelvic floor, but after a few weeks you will be amazed how it becomes second nature.

Kegel exercises should take 8-20 weeks for noticeable improvement to occur. Combine the fast and slow exercises aiming to perform them for five minutes at least three times a day.

**Slow Kegel Exercises**
1. Sit, stand or lie with your knees slightly apart
2. Slowly tighten your pelvic floor muscles starting with your anus
3. Tighten around your vagina
4. Squeeze both areas and as hard as you can and lift
5. Hold for the ten seconds, then relax

**Fast Kegel Exercises**
1. Sit, stand or lie with your knees slightly apart
2. Quickly tighten your pelvic floor muscles starting with your anus
3. Tighten around your vagina
4. Squeeze both areas and as hard as you can and lift
5. Hold for two seconds, then relax
How does physical activity help?

What activities are best?

The good news is that regular activity can help manage many of the symptoms of menopause. Physical activity helps to:

Reduce and prevent symptoms, such as
- Sleep disturbances, insomnia
- Joint pain
- Anxiety, irritability, depression
- Hot flushes
- Vaginal and bladder atrophy

Reduce your risk of
- Heart disease
- Osteoporosis
- Weight gain

Improve and increase your
- Strength, stamina, flexibility, energy
- Function of vital organs
- Condition of heart, lungs and muscles