KNOWLEDGE, ATTITUDE AND SELF-CARE OF POSTMENOPAUSAL WOMEN IN THE RURAL AREA SAKHONNAKORN PROVINCE, THAILAND

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KNOWLEDGE, ATTITUDE AND SELF -CARE OF POSTMENOPAUSAL WOMEN IN THE RURAL AREA OF SAKHONNAKORN PROVINCE, THAILAND

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ABSTRACT

Menopause is a physiological change which has several effects on the physical and mental health of women. The objectives of this cross-sectional survey research are to study knowledge, attitude and self-care of post menopausal women in the rural area of Sakhonnakorn Province, Thailand. Data was collected by interviewing 115 post menopausal women who live at Vanonnivas District in Sakhonnakorn Province. Descriptive statistics included frequency, percentage, mean and standard deviation. Chi-square test and Pearson's Product Moment Coefficients were used for hypothesis testing of association at the significance level of α=0.05 by using the SPSS V.14 statistical program.

The results of the study showed that mean age of postmenopausal women was 57.10±3.78 years. Most postmenopausal women (94.8 %) completed primary school. Ninety nine point one percent were married and 88.7 % had more than 4 children. Most women were farmers (80.9 %). Their average family income was 4,851±5,734 bath per month. Most (90.4 %) had universal coverage health insurance for health care. Most (65.2 %) had had cessation of menstruation for 5 years or more. Regarding knowledge, most of them (76.6 %) had fair or low level of knowledge about menopause with the mean score of 8.3± 2.77 from 15 question, and 67.0 % had fair or low attitude towards menopause. Twenty nine percent had low level of self-care. Regarding source of knowledge about menopause, most of them (38.3 %) had got knowledge from friends. Other sources of knowledge were less common. The factor which had significant association with level of knowledge of menopause was marital status (α<0.02).

In conclusion, knowledge and attitude of postmenopausal women in the rural area was rather low. Thus knowledge or advice about menopause and self-care should be provided by more appreciate sources of knowledge such as by community radio or from health personnel and hospital staff, and should be widely disseminated for improving self-care during the postmenopausal period.

KEY WORDS : POSTMENOPAUSAL WOMEN

69 pp.

ความรู้ ทัศนคติ และการดูแลตนเองของสตรีวัยหมดประจำเดือนในชนบทจังหวัดสกลนคร
(KNOWLEDGE , ATTITUDE AND SELF - CARE OF POSTMENOPAUSAL WOMEN IN THE RURAL AREA OF SAKHONNAKORN PROVINCE, THAILAND)

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บทคัดย่อ

การหมดประจำเดือนเป็นการเปลี่ยนแปลงตามธรรมชาติ มีผลต่อทั้งร่างกายและจิตใจของสตรี การศึกษาเชิงสำรวจแบบภาคตัดขวางนี้ มีวัตถุประสงค์เพื่อศึกษา ความรู้ ทัศนคติ และการดูแลตนเองของสตรีวัยหมดประจำเดือน ในชนบท จังหวัดสกลนคร การเก็บข้อมูลโดยใช้แบบสอบถามสตรีวัยหมดประจำเดือน 115 คนที่อาศัยอยู่ในอำเภอวานรนิวาส จังหวัดสกลนคร การวิเคราะห์ใช้สถิติ ความถี่ ร้อยละ ค่าเฉลี่ย ส่วนเบี่ยงเบนมาตรฐาน ใช้ Chi-square และ Pearson's Product Moment Coefficient เพื่อทดสอบสมมติฐานที่ระดับนัยสำคัญทางสถิติที่ α =0.05โดยใช้โปรแกรมสำเร็จรูปSPSS V.14

ผลการศึกษาพบว่า กลุ่มตัวอย่างมีอายุเฉลี่ย 57.10 ± 3.78 ปี ร้อยละ94.8 จบชั้นประถมศึกษา ร้อยละ99.1 แต่งงาน ร้อยละ 88.7 มีบุตรมากกว่า 4 คน ร้อยละ 80.9 ของสตรีมีอาชีพเกษตรกร รายได้ครอบครัวเฉลี่ย 4,851±5,734 บาทต่อเดือน ร้อยละ 90.4 มีสิทธิ์การรักษาเป็นประกันสุขภาพถ้วนหน้า ร้อยละ 65.2 หมดประจำเดือนมานานเกิน 5 ปี ร้อยละ 77.6 มีความรู้เกี่ยวกับการหมดประจำเดือนอยู่ในระดับต่ำถึงปานกลาง (8.3± 2.27) และร้อยละ 67.0 มีทัศนคติเกี่ยวกับการหมดประจำเดือนอยู่ในระดับปานกลางค่อนข้างต่ำ ส่วนการดูแลตนเองเมื่อหมดประจำเดือน ร้อยละ 29.0 ยังดูแลตนเองได้ในระดับต่ำ เมื่อพิจารณาแหล่งความรู้เกี่ยวกับการหมดประจำเดือนส่วนใหญ่ร้อยละ 38.3 ได้รับความรู้จากเพื่อน ส่วนแหล่งความรู้อื่นได้รับในระดับต่ำกว่า ปัจจัยทางด้านประชากรที่มีความสัมพันธ์อย่างมีนัยสำคัญทางสถิติความรู้เกี่ยวกับการหมดประจำเดือน คือ สถานะภาพสมรส (α<0.02)

โดยสรุป ความรู้และทัศนคติเกี่ยวกับการหมดประจำเดือนของสตรีวัยหมดประจำเดือนในชนบท ยังอยู่ในระดับต่ำดังนั้นควรมีการเผยแพร่ความรู้และคำแนะนำเกี่ยวกับการหมดประจำเดือนและการดูแลตนเองเมื่อหมดประจำเดือน โดยแหล่งความรู้ที่ถูกต้อง เชื่อถือได้ เช่น วิทยุชุมชน,เจ้าหน้าที่สาธารณสุข และเจ้าหน้าที่โรงพยาบาล เพื่อให้สตรีสามารถปฏิบัติตัวและดูแลตนเองเมื่อหมดประจำเดือนและลดอาการที่มีผลกระทบต่อชีวิตประจำวันได้

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CHAPTER I
INTRODUCTION

1.1 Rationale and Justification

Menopause is defined as absence of menstrual periods for 12 months. The menopausal transition starts with varying menstrual cycle length and ends with the final menstrual period. Perimenopause means "around the time of menopause." It is not officially a medical term, but is sometimes used to explain certain aspects of themenopause transition in lay terms. Postmenopause is the entire period of time that comes after the last menstrual period. Menopause is the time in a woman's life when the function of the ovaries ceases. The ovary, or female gonad, is one of a pair of reproductive glands in women. They are located in the pelvis, one on each side of the uterus. Each ovary is about the size and shape of an almond. The ovaries produce eggs (ova) and female hormones such as estrogen. During each monthly menstrual cycle, an egg is released from one ovary. The egg travels from the ovary through a Fallopian tube to the uterus. The ovaries are the main source of female hormones, which control the development of female body characteristics such as the breasts, body shape, and body hair. The hormones also regulate the menstrual cycle and pregnancy. Estrogens also protect the bone. Therefore, a woman can develop osteoporosis (thinning of bone) later in life when her ovaries do not produce adequate estrogen. Perimenopause is different for each woman. Scientists are still trying to identify all the factors that initiate and influence this transition period. (1,2,3)

There are about 37.5 million women in the United States reaching or currently at menopause (ages 40 to 59 years), according to data collected as part of the census in 2000. Menopause may trigger symptoms that cause women varying levels of discomfort. These can include hot flashes, changes in vaginal tissue, weight gain and mood swings. Menopause also raises the risk of various health disorders, including weakened bones (osteoporosis) and various heart conditions. Women can reduce the risk of experiencing some of the symptoms and conditions with various lifestyle

habits, such as exercising regularly and eating a healthy diet. Because of increased life expectancy, women today may live as much as one-third to one-half of their lives after menopause. For this reason, women should be careful to make lifestyle choices that can help them live healthy, productive lives during these years.(4) One-third of a women's life is spent in the estrogen-deficient, postmenopausal stage. It has been estimated that, by the year 2000, there will be 35 million women over age 65 than 5 million over 85, increasing by the year 2040 to approximately 65 million women over 65 and 10 million over 85.Less than 20 % of women over 65 are neither receiving hormonal therapy nor any other non-hormonal modalities to prevent and/or treat osteoporosis and cardiovascular disease.(1)

A women at age 50 with no unusual risk factors has a life expectancy of 82.8 years. Her lifetime risk of developing cardiovascular disease is 46.1% and of dying of it is 31 %. For stroke, these figures are 19.8 % and 8 % .For hip fracture , the risk of its occurrence is 15.3 % and 1.5 % for death as a sequelum .There is a 10.2% lifetime risk of developing breast cancer and a 3 % probability of dying of its. For women with a uterus, there is a 2.6 % lifetime risk of developing endometrial cancer and only a 0.3 % chance of dying from it. These major health issues will be diseased in detail as will non-threatening issues such as hot flashes, vulvovaginal complaints, psychological well-being and life style considerations. Hormonal therapy not only assists in the prevention of the diseases just mentioned, but also increase the quality of life and life expectancy.(1,2)

This research which aimed to study about knowledge attitude and self care of post menopausal women in the rural of Sakhonnakorn Province.Demographic factors included age, marital status, number of children, education level, income of family, occupation, occupation husband, source of health insurance. Sakhonnakorn Province is in the Northeastern of Thailand where poverty is prevail. In the rural area women were less education and more dependent. It is interesting to study the knowledge, attitude and self care of these post menopausal women in the rural area.

1.2 Research Objectives

1. Level of knowledge, attitude toward menopause among postmenopausal women in rural area of Sakhonnakorn Province.
2. Self care about menopausal symptoms among postmenopausal women in rural area of Sakhonnakorn Province.
3. Association between demographic characteristics and knowledge and attitude toward menopause among postmenopausal women in rural area of Sakhonnakorn Province.

1.3 Scope of the Study

This study was a retrospective research gathering data form recall memories. Every answers of the women are correct the study should only applied women who live in rural area in the northeastern region of Thailand.

1.4 Research Variables

Independent Variables

Demographic

- Age
- Marital Status
- No. of children
- Education
- Income
- Occupation
- Occupation of husband
- Source of health insurance

Dependent Variable

1. knowledge about menopause
2. Attitude toward menopause
3. Self care in postmenopausal women

1.5 Operational Definitions

Postmenopausal women means cassation of menstruation for 12 months consecutively.

Age means the full year age of postmenopausal women.

Marital status means social status of living as a couple by marriage or not.

No. of children means the number of living children.

Education means the highest education level of the postmenopausal women of Vanonnivas District Sakhonnakorn Province.

Income means salary or money received in a month.

Occupation means women who had work focus five main careers; agriculture, employer, merchant, house wife, government officer.

Occupation of husband means husband of women he had work focus five main careers; agriculture, employer, merchant, house wife, government officer.

Knowledge about menopause means scores that women got form answering 15 questions about menopause correctly. Knowledge about menopause was categorized in to 3 level

Good Level : The score was more than 10.5

Fair Level : The score was 7.5-10.5

Low Level : The score was less than 7.5

Attitude toward menopause means scores that women got form answering 10 questions about menopause correctly. Attitude toward menopause was categorized in to 3 level

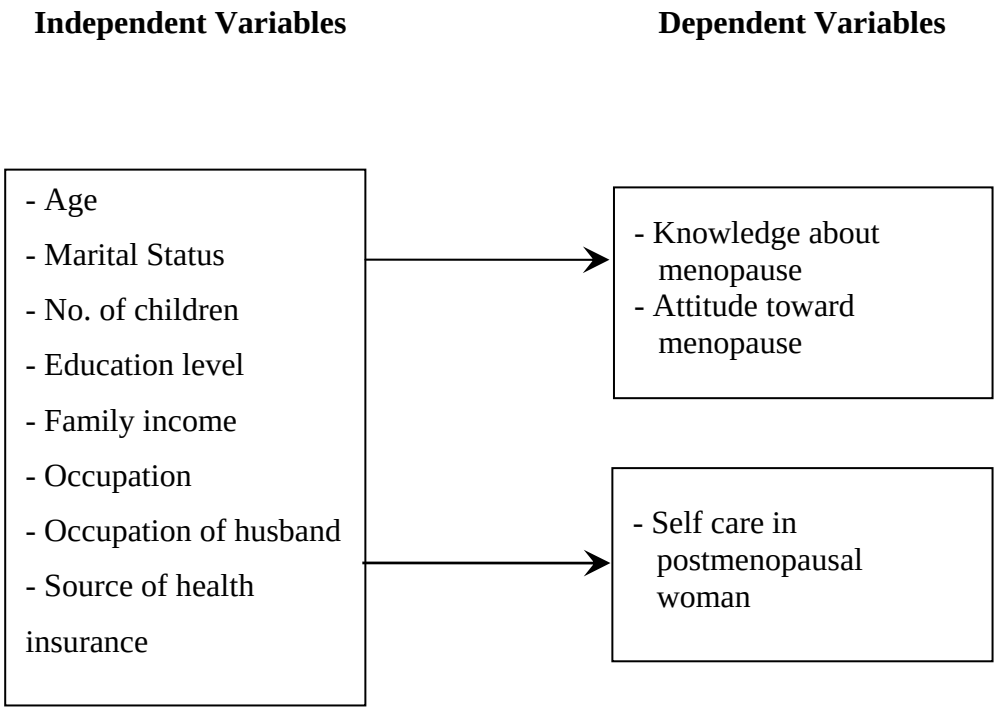
Good Level : The score was more than 3.4

Fair Level : The score was 2.8-3.4

Poor Level : The score was less than 2.8

Self care means the production of action, practice directed to self or environment in order to regulate one's functional in the interest of one's life, integrated functioning, and well-being of the postmenopausal women.

1.6 Conceptual Framework



1.7 Expected Outcome and Benefits

1. Nurse and health care professionals can apply the knowledge from this study in developing the ability of menopausal woman in managing menopausal symptoms effectively. The findings also serve as fundamental knowledge in providing and improving health service symptoms.

2. It serves as information for future studies in menopausal related studies.

CHAPTER II
LITERATURE REVIEW

Reviewed this chapter, concepts about menopause and self care were. The presentation will be organized into different topics as follow:

1. Knowledge about menopause
   1.1 Definition
   1.2 Incidence
   1.3 Stage of menopause.
   1.4 Physiologic change
   1.5 Mental change
   1.6 Symptoms.
2. Self care about menopausal symptoms among postmenopausal women.
3. Research studies related to postmenopausal woman and self care.

1. Knowledge about menopause

1.1 Definition

Menopause is defined as absence of menstrual periods for 12 months. The menopausal transition starts with varying menstrual cycle length and ends with the final menstrual period. Perimenopause means "around the time of menopause." It is not officially a medical term, but is sometimes used to explain certain aspects of themenopause transition in lay terms. Postmenopause is the entire period of time that comes after the last menstrual period. Menopause is the time in a woman's life when the function of the ovaries ceases. The ovary, or female gonad, is one of a pair of reproductive glands in women. They are located in the pelvis, one on each side of the uterus. Each ovary is about the size and shape of an almond. The ovaries produce eggs (ova) and female hormones such as estrogen. During each monthly menstrual cycle, an egg is released from one ovary. The egg travels from the ovary through a Fallopian tube to the uterus. The ovaries are the main source of female hormones,

which control the development of female body characteristics such as the breasts, body shape, and body hair. The hormones also regulate the menstrual cycle and pregnancy. Estrogens also protect the bone. Therefore, a woman can develop osteoporosis (thinning of bone) later in life when her ovaries do not produce adequate estrogen. Perimenopause is different for each woman. Scientists are still trying to identify all the factors that initiate and influence this transition period. (1,2)

1.2 Incidence

There are about 37.5 million women in the United States reaching or currently at menopause (ages 40 to 59 years), according to data collected as part of the census in 2000. Menopause may trigger symptoms that cause women varying levels of discomfort. These can include hot flashes, changes in vaginal tissue, weight gain and mood swings. Menopause also raises the risk of various health disorders, including weakened bones (osteoporosis) and various heart conditions. Women can reduce the risk of experiencing some of the symptoms and conditions with various lifestyle habits, such as exercising regularly and eating a healthy diet. Because of increased life expectancy, women today may live as much as one-third to one-half of their lives after menopause. For this reason, women should be careful to make lifestyle choices that can help them live healthy, productive lives during these years. (3,4)

One-third of a women's life is spent in the estrogen-deficient, postmenopausal stage. It has been estimated that, by the year 2000, there will be 35 million women over age 65 than 5 million over 85, increasing by the year 2040 to approximately 65 million women over 65 and 10 million over 85.Less than 20 % of women over 65 are neither receiving hormonal therapy nor any other non-hormonal modalities to prevent and/or treat osteoporosis and cardiovascular disease. (1)

A women at age 50 with no unusual risk factors has a life expectancy of 82.8 years. Her lifetime risk of developing cardiovascular disease is 46.1 % and of dying of it is 31 %. For stroke, these figures are 19.8 % and 8 % .For hip fracture , the risk of its occurrence is 15.3 % and 1.5 % for death as a sequelum .There is a 10.2 % lifetime risk of developing breast cancer and a 3 % probability of dying of its. For women with a uterus, there is a 2.6 % lifetime risk of developing endometrial cancer and only

a 0.3 % chance of dying from it. These major health issues will be diseased in detail as will non-threatening issues such as hot flashes, vulvovaginal complaints, psychological well-being and life style considerations. Hormonal therapy not only assists in the prevention of the diseases just mentioned, but also increase the quality of life and life expectancy.(1,2)

1.3 Stage of menopause

This can be divided into three stages: the pre-, peri-, and postmenopause. The menopause is a point in time that signals the end of the premenopause and the beginning of the postmenopause. (2)

Premenopause This refers to the years when your menstrual cycle is regular; in other words, most of your fertile, reproductive life. However, “premenopause” is also sometimes used to refer to the early years of the climacteric, after the age of 40, when menstrual periods may become irregular or heavy. If your doctor ever tells you that you are premenopausal, you should ask for a precise definition of what he or she means.

Perimenopause This is the stage lasting several years on either side of your last menstrual period. This means that the perimenopause is, in part, a retrospective diagnosis, since it’s only when your periods cease that you can measure backwards tow years in time to when the perimenopause began. Vague symptoms that you may not have connected in your own mind can become significant when viewed as part of the perimenopause. It’s during this time that you notice most physical changes, when your periods many become irregular, and when hot flushes may start.

Menopause This has a very precise meaning – the menopause is your final menstrual period. This is another date that can only be identified retrospectively, when you have not had a menstrual bleed for 12 months. In other words, it is impossible for a woman to know the exact moment in time that she is experiencing the menopause.

Postmenopause This overlaps with the end of the perimenopausal stage and will extend into the years that follow your last menstrual period until the end as a woman ages, her supply of eggs declines. Menopause occurs naturally after the woman's supply of follicles has been depleted and menstruation ends completely.(6, 7)

The average age of women at menopause today is 51.4 years although it can occur as early as age 40 to as late as the early 60s. Women now have a life expectancy of more than 80 years. Currently, women can expect to live some 30 or 40 years of their life in the postmenopausal state. Menopause is not a disease. However, many conditions are associated with estrogen depletion, including heart disease, osteoporosis, and other complications. Fortunately, effective treatments are available for these conditions. In a number of studies, most women have reported menopause as a positive experience and have welcomed it with relief and as a sign of a new stage in life. (6)

1.4 **Physiologic change** (2)

Some women find the menopause particularly disconcerting because they feel that their bodies are changing, even letting them down, and they really can't understand why or how. You will be better prepared to cope with the following changes if you have an understanding of why they are taking place or what you can do to prevent them

Urogenital tissue

The cells of the urethra and the vagina contain oestrogen receptors that bind with oestrogen, keeping the tissues healthy. When oestrogen levels start to fall at the menopause, the results include a decrease in blood supply to the tissues and a lowering of cellular starch (energy). The latter leads to a change in the pH of the vagina so that it becomes more alkaline. This encourages vaginal soreness, itchingand infections. Similar cellular changes are seen in the lining of the urethra, giving rise to urgent, frequent, or uncomfortable urination. A local application of oestrogen cream will reverse these changes and relieve symptoms. Urogenital problems will also respond to other forms of HRT.

Uterus

This is a somooth muscle with and inner lining, known as the endometrium, which contains glands and blood vessels. The endometrium builds up and breaks down each month throughout a woman's fertile life, unless she is pregnat. In about half of all menopausal women the endometrium begins to thin out, becomingatrophic endometrium. The endometrial thickness depends on how much oestrogen is present

in a woman's body, whether manufactured by conversion from adrenal androgens (male sex hormones) or introduced to the body in the form of HRT.

The cervix is the neck of the uterus that dips into the upper part of the vagina. During fertile life there are sensitive nerves in the cervix that, when stimulated during sexual intercourse, give between 30 percent and 50 percent of women a deeply satisfying feeling. As the cervix ages, these nerves gradually disappear and the sensitivity of the cervix to deep penile thrusting can begin to wane. However, the cervix does not become completely insensitive and can still contribute to orgasm.

Ovaries

As women approach the menopause, the declining number of eggs in the ovaries means that ovulation will not necessarily take place in every 28-day cycle. This in turn means that the secretion of oestrogen becomes erratic and women may experience menopausal symptoms, such as hot flushes and night sweats. After the menopause, the egg follicles in the ovary no longer grow and mature each month. Ovulation does not occur, and this means that there is no ruptured egg follicle (corpus luteum), which means that no progesterone is produced.

The outer shell of the ovary, which produced oestrogen and progesterone during your fertile life, become thinner and wrinkled, and the entire ovary shrinks. Howerve, during the postmenopause the inner part of the ovary, called the stroma, continues to actively secrete hormones, chiefly the male hormones, androstenedione and testosterone. The latter is important in keeping pu pyur energy and enthsuiasm for life. Unfortuately, it also promotes changes in your fat metabolism that increase your risk of suffering from conditions such as heart disease and stroke. Androstenedione is converted in small quantities to the weak female hormone, oestrone, which helps to maintain the intergrity of the pelvic organs, the skin, the hair, and the vagina. If you have your ovaries surgically removed, you lose and important source of postmenopausal oestrogen and it is important to take HRT.

Vagina

When oestrogen levels drop, the vagina begins to atrophy (becomes thin and dry). While not all women lose oestrogenic stimulation of vaginal tissue as they get older, the activity of the glands in the vagina do begin to wane for many women. Healthy mucus is no longer secreted to keep the vagina lubricated, and it becomes

more prone to infection and abrasions, which can lead to pain and bleeding during intercourse. Such vaginal discomfort is a primary reason for a loss of sex drive in postmnopausal women, and you may find that you need to use a lubricant to enable penetration. If you go to doctor, she may prescribe oestrogen pessaries or cream to restore the vaginal lining to its premenopausal state. Research shows that women who main sexually active after the menopause suffer less from vaginal atrophy than women who do not mastrubate or have sexual intercourse.

Breast

As get older the breasts tend to sag and flatten – the larger the breasts, the flatter they may become. With the menopause there is a reduction of oestrogen stimulation on all tissues in the body, including the breast tissues, and as a result, they lose their earlier fullness. There is also a reduction in the glandular tissues of the breast and an increase in fat cells. Women who take HRT will find that breast fullness is restored to a large degree and this will remain for as long as hormones are taken. Breast cancer is a risk after the menopause, and the later the menopause, the higher the risk. If have breast cancer should seek advice from a doctor or gynaecologist about HRT .

Abdomen

If exercise regularly, should not experience any sudden changes in the size and shape of abdomen, however, if stop having periods and notice that abdomen suddenly increases in size, should consult doctor, because a sudden enlargement of the abdomen is sometimes the only sign of an ovarian tumor. Alternatively, if feel bloated or distended and waist size has grown, may be eating a diet that is too low in fiber, or taking insufficient exercise. If don’t do much exercise, you will experience a gradual loss of abdominal wall tone. Will find that simply cannot pull in tummy the way used to. Healthy abdominal muscles support the internal organs. Regular muscle exercise makes a huge difference not only to the shape of your abdomen, but also to self-image – and never too old to start a fitness program. Wearing a girdle will actually promote the development of lazy musculature, leading to an increase in abdominal bulging.

Bones

Despite its solid appearance, bone is actually porous and becomes more porous with age. There are two types of cells that actively influence bone health.

Osteoblasts are responsible for building up bone, and osteoclasts are responsible for the removal or resorption of bone. At the time of the menopause the activity of the osteoclasts becomes greater than the activity of the osteoblasts. In other words, more bone is removed than is created, and bone mass and density are lost. The decline of oestrogen is responsible for this.

Vasomotor system

This is the system of tiny blood vessels under the skin. Dilation occurs when blood vessels relax and fill with blood, and constriction occurs when blood vessels narrow and empty. A women experiencing a hot flush will have fully dilated blood vessels, which will cause the skin to become swollen, red, and warm. Constricted blood vessels will cause the skin to become thin, pale, and cold.

Heart and blood vessels

The exact effect the menopause has on the heart and blood vessels is not fully understood. What is known is that, irrespective of age, women with functioning ovaries are less prone to heart disease than women who have gone through the menopause either naturally or after surgical removal of the ovaries.

1.5 Mental change

Feelings such as tension, anxiety, depression, listlessness, irritability, tearfulness, and mood swings can occur at any age, but they rarely occur together, or as frequently as they do during the menopause. If are experiencing several negative feelings simultaneously, it may be helpful to know that menopause is the reason.

For many women, menopausal mood changes resemble a roller coaster ride. Women describe subtle sensations such as trembling, fluttering, unease, and discomfort. More severe feelings of anxiety or panic can arise with little provocation. Tasks that you used to be able to tackle can leave you in total disarray. Mood swings from elation to despondency are common. Your patience is easily exhausted. The future may look hopeless, your loss of self – esteem is precipitous, and feel truly depressed. Menopause causes mental problems to women in terms of body image and self-esteem. (6,7,8)

Body Image

They are sensitive about their body, posture and complexion. In menopausal women, their skin wrinkles, their breast gets small and sack, their bodies get ort of shape, they lose their hair or their hair turns gray, and their beauty goes. Menopausal women feel they have lost their sex appeal and beauty. They become anxious and depressed.

Self-Esteem

Self-esteem is significant to the personal mental stability, It is related to the personal perception of self-value and acceptance from others. Menopausal women experience an estrogen decrease and their bodies change negatively. It has become a symbolic change of the female status, which has both positive and negative effects. Those who perceive it as positive feel that they no longer have to worry about menstruation. Those who perceive it as positive feel that they no longer have to worry about menstruation. Those who perceive it as negative feel that their strength and beauty are deteriorating. They feel that such changes mean old age or a meaningless life. Some think that the reproductive age is only valuable period. Once it is gone, their lives are also gone (6). Women who reach this age are not always able to accept these changes. They become sensitive to learn that their role has changed and they feel meaningless (7). Moreover, sudden changes such as the death of their husbands, children of their loved ones, retirement, divorce, their children moving out, can cause more mental instability and severity. In some cases where their family is ignorant and external interference such as financial trouble or failure in work is pressing, women tend to blame themselves. They think that living means being a burden to other people and commit suicide as a way out. (7,8)

It is apparent that menopausal women experience physical and mental changes. These problems affect menopausal women themselves, their family and society. These changes become their motivation in searching for solutions or methods in managing the symptoms in order to alleviate of relieve the impact. Correct and appropriate symptom management can help retain their health status and they can live happy and quality of lives when they reach old age. In order to increase the ability of self-care and menopausal symptom management according to individual symptoms, a study in menopausal symptom management in menopausal women is necessary. If

health workers understand the reasons and self-care behavior in managing symptoms, the health status of the community or society will greatly improve. The study will also serve as a guideline in developing effective symptom management ability, improving health care services, health studies and preventing any health hazards.(8,9)

1.6 Symptoms

The list of symptoms associated with the menopause is long, and at first glance may be daunting. Fortunately, no woman experiences the whole range of symptoms – you will probably only have a few and many women have none. The list shown below is long simply because it's helpful to know the array of disparate symptoms, especially if you need to discuss your treatment with a doctor. The physical effects of the menopause are so diverse, it is sometimes hard to connect them to a single cause. There are some classic symptoms, such as hot flushes and mood swings, that women may readily associate with the menopause, but others, such as poor bladder control or back pain, often appear to be just incidental. All the symptoms blow are directly of indirectly related to a drop in oestrogen levels.

Hot flushes

These are experienced by more than 85 percent of menopausal women, although their frequency and severity varies greatly from woman to woman. During a hot flush, a woman can perspire so profusely that perspiration runs down her face, neck, and back; her skin will rise in temperature, her heart will beat faster, and she may experience palpitations. Very occasionally, a woman may faint during a hot flush, but this is rare.(2)

Hot flushes occur because the brain decides that the body is overheated. We now know that this is because the natural temperature set-point (above which the brain considers the body is too hot, and below which the brain consider the body too cold) becomes lowered. This means that even under normal conditions, the brain may think that the body's temperature is too high, and respond by increasing the blood flow through the skin. The heated skin reddens and begins to perspire. Whey the sweat starts to evaporate, the body temperature cools down again.(9,10,11)

Even though a hot flush may feel most severe in the head, face, and neck, the rise in temperature occurs throughout the body. Even the finger and toe temperatures rise sharply at the beginning of a flush.

In a Danish study of menopausal women, a third of those interviewed continued to have hot flushes for ten years after their last period. In the most severe cases, women had hot flushes six or seven times every hour – a pattern that could continue for years. Two out of three women suffered hot flushes well before their last menstrual period, but for most of these women the frequency went on to increase dramatically at the menopause, and continued for about the next five years.(2)

The discomfort from a hot flush is unique – it's not the same as simply being overheated. In one study, investigators tried to induce hot flushes in menopausal women using hot water bottles and blankets. They found that applying external heat does not produce the same dramatic changes in heart rate and blood pressure that a menopausal flush does. However, hot flushes can be aggravated by hot weather.

Hot flashes-sudden flashes of heat especially on head, throat and chest. It may last a few seconds to several minutes. This symptom appears in about 10-20% of women aged 40 years or older with irregular menstruation. Within 2 years of absence of menstruation, 40-58% of women experiences hot flashes (8, 10)

Night sweats

The night – time equivalent of the hot flush is the night sweat, in which you wake up hot and drenched in perspirations. Most women who experience night sweats also have hot flushes during the daytime, but the reverse isn't always so. Night sweats can very occasionally be a symptom of stress, or a disease that is unrelated to the menopause – consult doctor will be able to make a diagnosis. (12, 13)

Sleeplessness in menopausal women is nearly always linked to night sweats. Women describe waking up, throwing off their bed covers to relieve the intensity of a night sweat, and being so drenched in sweat that they have to get up to change their nightclothes and bed linen. In the most severe cases, this can happen several times a night.

A night sweat is a physiological process involving a fever that lasts a minute or two and then disappears. The heart rhythm goes wild, the body temperature rises, and the woman is left with a sweaty face and chest, followed by a felling of being

chilled. Some women with severe night sweats become very depressed. Furthermore, their depression doesn't go away until the night sweats are controlled.

Vaginal and urinary symptoms

Urogenital problems are very common during the menopause, yet only four in ten women consult their doctor about them. Anatomically, the vagina and the lower urinary tract lie very close, separated by just a few layers of cells. They both respond to a lack of oestrogen by becoming thin and dry.

Urinary symptoms typically include discomfort in passing urine, and frequent and urgent urination, even when there is very little urine in the bladder. There may also be some dribbling because the sphincter muscle guarding the exit from the bladder becomes weak due to low oestrogen levels. Sometimes urine escapes from the bladder on laughing, coughing, or carrying a heavy weight. This is called stress incontinence and it is due to increased pressure inside the abdomen squeezing urine form the bladder. With any or all of these symptoms you may have genital dryness and itching. Vaginal soreness, particularly during or after intercourse because the vagina fails to lubricate, is also common among menopausal and postmenopausal women. (2)

Muscle and joint symptoms

Collagen is a protein that provides the scaffolding for every tissue in the body, and when it begins to disintegrate at the menopause, muscles lose their bulk, strength, and coordination, and joints become stiff. Muscles become more prone to soreness and stiffness after exercise, and joints may swell so that their mobility becomes restricted. Retain fluid, get pins and needles or numbness in the hands. These are symptoms of carpal tunnel syndrome caused by tissues bloated with water pressing on the nerve to the hand and the fingers.

Osteoporosis causes aches and pains all over the body, especially in the upper back due to the thinning of vertebral bones.

General fatigue at the menopause may be profound. Besides underused muscles and joints there are other causes of chronic fatigue, suck as low blood sugar, anemia, and an under active thyroid gland. Ask your doctor to check all of these experience disabling fatigue.(2)

Skin, Hair, Eye, Mouth, And Nail Symptoms

The lowered oestrogen levels that occur at the menopause cause changes in the skin, hair, nails, eyes, mouth, and gums. These changes are in part due to the disintegration of collagen fibres and the weakening of the protein, elastin, which gives connective tissue its strength and suppleness. Lack of collagen leads to a decrease in skin thickness and suppleness, dry hair, brittle nails, sore eyes, mouth dryness, gum shrinkage and an increase in joint stiffness. One of the most noticeable changes is the appearance of wrinkles in the facial skin. The reduction in blood flow in the skin and the subcutaneous tissues contributes to the loss of skin firmness, as does shrinkage of underlying muscles. Deterioration of nerve endings in the ageing skin can lead to itchiness and a condition called formations. This is an intense tingling that some women describe as a feeling that insects are crawling across their skin. The word is derived from the Latin word for ant, “formica”. Formication is a classic symptom of menopausal distress. In a study of 5000 women, one in five suffered from formication within 12 – 24 months after their last menstrual period. About one in ten women continue to suffer from formication for more than 12 years after the menopause. Although it disappears eventually, its precise cause is still not completely understood.

The breasts also increase in size during sexual arousal in young women – by as much as a quarter in some cases. The rush of blood to the tiny veins of the breasts that causes this does not occur so often after the level of oestrogen has declined.

Sexual symptoms

A common myth about the menopause is that it makes the beginning of a woman’s sexual decline. Nothing could be further from the truth. The majority of women can continue to experience sexual pleasure well into old age, indeed as long as their health remains good. Some women even report that their sexual enjoyment starts to increase after the menopauses. This may be due to a higher testosterone to oestrogen ration than before. Most menopausal women, however, notice some changes in the way their bodies respond during arousal and sex. This is often due to physical changes in the urogenital tract rather than a decreased psychological desire for sex. Research on sexual pleasure by Alfred Kinsy some decades ago has shown that women who have an enjoyable sex life before the menopause are likely to continue to enjoy sex after it. On the other hand, for women who have not enjoyed sex

throughout their lives, the menopause is more likely to be associated with a decrease in all kinds of sexual activity. (14,15)

One of the most common sexual problems after the menopause is lack of lubrication. The vaginal lining may actually crack and bleed and this makes penetration painful, and sometimes impossible.

In youth, blood flow out of the genitals is slow during arousal, causing swelling and sensitivity to touch. After the menopause, there is less engorgement of the clitoris, the vagina, and the vulva, leading to subdued arousal.

Breasts may no longer be so sensitive to touching and stroking. Another part of the sexual response that disappears is the “sex flush” – the rash that may appear on a woman’s chest and others parts of the body just before orgasm. This does not affect sexual enjoyment, but it does show that your body responds to sexual arousal differently from the way it used to.

In a young women the vagina expands during sexual arousal to allow easy penetration. After the menopause, the vagina does not expand so much, but it still remains large enough to accommodate an erect penis (as long as you allow time to achieve proper lubrication).

Healthy adrenal glands are also critical to sex drive. Long – term stress, such as bereavement, divorce, moving house, and family problems can adversely affect glandular activity. Internal “stress”, such as too much sugar, fat, coffee, or alcohol, can have the same effect. Finding ways of handling stress and eating a healthy diet are conducive to a good sex life.

Sexual desire can also be diminished by certain drugs, such as tranquillizers, muscle relaxants, antidepressants, amphetamines, diuretics, antihypertensives, and hormones. Alcohol, smoking, coffee, overwork, tension, and depression have the same effect.

Women who have had a hysterectomy or surgical removal of the ovaries may also experience a diminished enjoyment of sex and a reduced ability to reach orgasm.(16)

Insomnia

If felling depressed or anxious, suffering from night sweats it can become difficult to get to sleep, and common to wake early in the morning. Eventually, a good night's rest can become a rarity.

Laboratory studies have shown that women who have normal levels of oestrogen, or who take HRT, fall asleep faster than women who don't. Women who have adequate levels of oestrogen also spend more time in the deepest (dream) stage of sleep, and they feel more refreshed when they awake. Dreaming seems to be particularly important for the feeling of rest and renewal that comes from sleeping. Without oestrogen, we can sleep for a whole night but still feel tired on waking.(16,17)

Stomach and bowel symptoms

Bloating with abdominal distension may be a problem during the menopausal years. It is usually due to gas in the large intestine, produced by fermentation in the bowel. As we age, small pockets of tissue may balloon out from the bowel, giving rise to the condition called diverticulitis. Within these small pockets (diverticula) food may lodge, become stale, ferment, and produce large amounts of gas. The intestine may end up coated with food remnants that form small centres of fermentation. It is quite common for the sufferer to wake in the morning with a flat stomach and for the abdomen to swell as the day progresses, so that by bedtime the swelling resembles a six – month pregnancy! During the night, lack of food and sugar in the intestine allows fermentation to abate. After a breakfast that contains sugars and yeasts, fermentation in the bowel flares up again. Alternatively, bloating may be a side – effect of taking HRT. (2,10,12)

Constipation is another frequent symptom at the menopause because intestinal motility (movement) is affected by the sex hormones. We know that progesterone reduces bowel movements so that the motions become infrequent, dry, and pebble – like. Oestrogen, on the other hand, speeds up bowel movements and the stools revert to a normal consistency and frequency.

Breast symptoms

Most women experience breast discomfort in the week before they menstruate, due to fluid retention in the breast tissue and a consequent increase in breast tension. As women reach their early 40s, this discomfort may develop into a more severe pain called mastalgia. The breasts become hard, tender, and extremely painful. An attack of mastalgia can last for up to ten days.

In severe cases, the breasts can be so painful that you cannot bear anything to touch them. The pain is especially intense in the nipples, and may keep you awake at night. Even turning over in bed can be agony.

It is estimated that 70 percent of women in Britain suffer from breast pain at some time in their lives, but particularly in the pre – and perimenopausal years. It is one of the most common symptoms in women attending a breast clinic and the most frequent reason for breast – related visits to the doctor. Sadly, some GPs can be unsympathetic, and reluctant to treat breast pain, perceiving it as non – pathological or part of a “woman’s lot”. (2).

Mastalgia is often cyclical, fluctuating with the menstrual cycle and usually becoming worse immediately before menstruation. But non – cyclical mastalgia can occur at any time of the month and is most common in women over 40 years of age. The causes are not completely understood, but mastalgia may stem from abnormal sensitivity of breast tissue to the fluctuation of the female hormones at the menopause. Diet can make this problem worse. Women who suffer from breast pain tend to have low levels of essential fatty acids and high levels of saturated fat in their blood – this appears to exaggerate the effects of female hormones on breast tissue. Cyclical pain may be a side – effect of oral contraceptives or HRT if the doses of hormone are too high. (10)

Weight gain

Some postmenopausal women strive to maintain their premenopausal weight. Medically this is quite unsound: the weight that you may gain at the menopause is due to a slower metabolism – something that affects both men and women as they grow older – and a decline in oestrogen levels, which affects the way that fat is distributed.

It is important to have a realistic outlook and be aware that changes in body shape happen to all postmenopausal women. Excessive or faddy dieting is unhealthy,

and to daily calcium requirements. Try using exercise as a means of maintaining muscle tone instead.

Lowering of the voice

There are two reasons for the voice deepening after the menopause. First, there is a relative increase in the amount of male hormones, or androgens, circulating in the blood. Long after the ovaries have stopped secreting oestrogen, they continue to secrete androgens. This relative excess of male hormone has a masculinizing effect on various organs of the body, including the larynx, causing a deepening of the voice.

The second cause can be an underactive thyroid or hypothyroidism. The voice becomes deep, gruff, and slightly hoarse, and there are other accompanying symptoms, such as thick, dry skin, hair loss, a tendency to feel the cold, weight gain, and mental and physical fatigue.

Heart symptoms

The earliest symptom of postmenopausal heart disease (heart problems are rare in premenopausal women because of the presence of oestrogen) is nearly always angina. This is a crushing pain in the middle of the chest brought on by effort, and alleviated by rest. Without rest, the pain can worsen and radiate up into the neck, teeth, and down the arm (usually the left arm but occasionally the right). Eventually the pain will become so bad that you are forced to stop what you are doing. Angina is a warning sign that insufficient oxygen is reaching your heart muscle. You should take any chest pain seriously and go to your doctor for a cardiac check – up.

Other symptoms relating to heart health are palpitations and shortness of breath on exertion. Find that normal exercise leaves you unusually breathless and climbing several flights of stairs gives a pumping, fluttery feeling in chest.

Emotional symptoms

Feelings such as tension, anxiety, depression, listlessness, irritability, tearfulness, and mood swings can occur at any age, but they rarely occur together, or as frequently as they do during the menopause. Experiencing several negative feelings simultaneously, it may be helpful to know that menopause is the reason.

For many women, menopausal mood changes resemble a roller coaster ride. Women describe subtle sensations such as trembling, fluttering, unease, and discomfort. More severe feelings of anxiety or panic can arise with little provocation.

Tasks that used to be able to tackle can leave in total disarray. Mood swings from elation to despondency are common. Patience is easily exhausted. The future may look hopeless, loss of self – esteem is precipitous, and feel truly depressed. (18)

The centres in the brain that control a sense of well – being, a positive state of mind, and a feeling of control and tranquility are aggected by the absence of oestrogen. Taking oestrogen supplements in the form of HRT can cause a dramatic return to normality.(10)

For some women, the emotional troubles troubles they experience around the menopause may mainly be due to the fact that their sleep is being interrupted by night sweats. People who are tired are often irritable and anxious. A major depression, although rare, can descend upon during menopausal years, and this is distinct from other emotional symptoms that experience, such as tearfulness and anxiety. The following are possible predictors of depression during the menopause:

- A past or recent history of stressful events, such as divorce or bereavement.
- A surgically induced menopause.
- Having negative expectations of the menopause.
- Severe hot flushes and nigh sweats.
- A family history of depressive illness.

Depression can be a debilitating illness that can last for weeks, months, or eve years if left untreated. It affects body, mood, thoughts, and severely interferes with normal life. As a woman more likely to experience a depression than a man is. Consult your doctor if experienced four of these symptoms for at least two weeks.

- Any extreme eating patterns, such as bingeing or periods of starvation.
- Unusual sleeping patterns, such as sleeping all the time or insomnia.
- Being exceptionally lethargic or restless.
- An inability to enjoy a once pleasurable activity; including a loss of sex drive.
- Debilitating fatigue or loss of energy.
- Feelings of worthlessness and self – reproach.

- Difficulty concentrating, remembering, and making decisions.
- Thoughts of death or suicide, or suicide attempts (see help straight away).

Intellectual symptoms

Forgetfulness is one of the most common symptoms that menopausal women complain of, and they may experience it ling before they actually stop menstruating. You may forget where you put something, you may miss appointments, and things that used to be easy to remember can suddenly require enormous effort. The ability to concentrate can also become difficult. These problems combined can make it hard to carry out work that involves complex assessments and major decision – making. Even minor decisions can sometimes be quite paralyzing.

Osteoporosis

Osteoporosis refers to changes in bone metabolism, which causes the loss of bone, and this is a direct effect of a decrease in estrogen. Estrogen plays an important role in preventing the loss of calcium in bones. Once the estrogen level decreases, the deterioration rate in bones is higher than the reproduction rate and this leads to a loss of bone mass. Menopausal women experience bone mass loss at the rate of 1-1.5 % per year and this continues on for 10-15 years (2, 6). The loss rate is highest during the first 5 years of menopause. Bone density is highest when women are at the age of 20-30 years (11). Its mass gradually decreases with the highest rate when they reach climacteric.

2. Self care about menopausal symptoms among post menopausalwomen

Menopausal symptom management among menopausal women varies depending on cultural health care, beliefs and intellectual base in their society. It also depends of the interpretation, perception and view of menopausal women because beliefs learned from society and culture is the basis for people in society (17, 18). This study divides menopausal symptom management into 3 methods: tolerate, self-care, and health personnel.

2.1 Self-care

Self-care is the means the production of action, practice directed to self or environment in order to regulate one’s functional in the interest of one’s life,

integrated functioning, and well-being. According to Orem's concept, self care is viewed as deliberate action that is gold-oriented. Orem's model includes three type of self care: universal (maintenance of air, water, food, etc.), developmental (related to life events such as birth and death), and health deviation (seek medicine assistance, carrying out medical treatment, learning to live with effect of pathologic condition).(19)

Self-care is the means preliminary process adopted by menopausal women when the body experiences abnormalities or changes due to menopause. It is a start and a basis for self-care. When abnormalities or indicative symptoms occur, menopausal women perceive the severity of the symptoms. They start to care for themselves in familiar ways. It can be self-initiated methods or a method suggested by their family, relatives, friends or surrounding people. Procedures and thinking methods are based on their folk, local and cultural beliefs and is aimed at treating or managing the menopausal symptoms (20) Once menopausal women experience physical abnormalities, some may observe the symptoms to see if they will lessen or go away. Some may take some self medicine, choose to avoid certain food, get more rest, do exercises, use hot compress, do meditation or consult with relatives or friends. This is all dependent on symptom experience, perception, knowledge and beliefs of menopausal women.(18)

Self care it is important to understand the concepts of self care agency is human's ability or power to engage in self care. The individual's ability to engage in self care is affected by basic conditioning factors. This basic conditioning factors are age, gender, developmental state, health state sociocultural orientation, health care system factor (i.e., diagnostic and treatment modalities), family system factors, pattern living(eg, activities regularly engaged in), environment factors and resource adequacy and availability.(20)

2.2 Health personnel

After self-care fails to alleviate symptoms of menopause, postmenopausal women will turn to seek help from the service sector that they believe to be the most effective health personnel or modern medicine. Postmenopausal women who perceive menopause as a crisis age of life will turn to doctors and are willing to take HRT

and/or require special attention from doctors to prevent them from any illnesses (12). Symptom management in the health personnel can be concluded as management such as HRT or calcium intake adopted by menopausal women who have been diagnosed by doctors or health personnel. (11)

Both the immediate and the long-term effects of the menopause have been shown to be improved by administering oestrogen and progesterone. Oestrogen therapy has been proven to improve the bone mineralization of osteoporosis and so reduce substantially the risk fractures. With respect to cholesterol and LDL level and raises the HDL function. This effect might be negated some what by the concomitant administration of progesterone. All patients should be fully informed about and risk of HRT,so that they can decried whether to commence treatment. In particular, women in the menopause who are below 45 years of age and women with osteoporosis or with a combination of risk factors for disease must discuss HRT thoroughly. Contraindications to HRT. Particular controversy exists over the risk of HRT in the development of breast cancer; recently it that been proved that there is a slight icreased risk, but this is likely to be offset by the improved morbidity form osteoporosis. The next decision in prescribing is whether the patient finds a monthly withdrawal bleed acceptable. The women might be suitable for continuous combined oestrogen and progesterone therapy, which should avoid monthly bleeds.(10,15)

3. Research studies related to post menopausal woman and self-care of menopausal woman

In 1995, Upakarakul L. studied 80 menopausal women in the slum areas of Muang District of Khon Kaen Province on their knowledge of menopause and self-care experiences. It was found that 78.9 % high level of knowledge of menopause and self-care.

Hot flash; 25 % of menopausal women who experienced hot flashes and sweats took showers often and used a fan. 15 % of them took self-procured medicine. 10 % of them accepted with endurance the symptoms and the other 10 % went to see a doctor.

Irritability, anger or sensitivity; 35 % of menopausal women who experienced mental problems such as tried to control their emotion. 22.5 % of them relieved their emotions in some fashions. 1.3 % did meditation or turned to religion. 8.7 % accepted with endurance the symptoms whereas 5 % consulted doctor. 5 % of them sought other measures.

Forgetfulness; 65 % of menopausal women accepted with endurance the symptom. 10 % consulted with a doctor or psychiatrist. 6.3 % took self-procured medicine and 5 % spent time taking notes or reviewing.

Urinary incontinence; 37.5 % accepted with endurance the symptoms whereas 3.7 % practiced bolding urination. 2.5 % took self-procured medicine. 1.3 % wore sanitary towels and 1.3 % consulted doctor.

Vaginal pain during intercourse; 11.2 % accepted with endurance the symptoms. The rest consulted a doctor or else avoided sexual intercourse. (21)

In 1998, Choi NY, Studied, a study on the degree of knowledge of menopause and management of menopausal women, This descriptive study showed that. The score of knowledge was the highest at the group 45-50, the high education, and the high number of family members. The score of management was the highest in self control category. No drinking & no smoking items were the highest. Sexual management and management by professional person were low score. The higher score of the knowledge of menopause, the higher score of the management. (22)

In 1997, Thamwirach P. and Wattananon Y. studied the knowledge of menopause and self-care of 96 nursing personnel in their climacteric age at Mahidol University, Siriraj Campus. It was found that 26.67 % of the sample group handled.

Hot flash by using fans or air-conditioners; 22.22 % accepted with endurance the symptoms. 30.77 % of the sample group tried to control.

Irritability, anger depressions; 12.82 % took up exercise and 14.81 % did meditation. 35.90 % meditate to tackle.

Forgetfulness; 25.64 % took notes whereas 23.08 % accepted with endurance the symptoms.

Urinary incontinence; 15.38 % practiced exercise for pelvic floor muscle. 10.26 % practiced holding urination. 11.11 % accepted with endurance the symptoms.

Vaginal pain during intercourse; 12.82 % applied lubricant. 13.33 % accepted with endurance the symptoms. 5.13 % avoided sexual intercourse. (23)

In 1999, Chaopotong P, studied, menopausal symptoms and knowledge towards daily life and hormone replacement therapy among menopausal women in Bangkok, This descriptive study showed that A total of 148 questionnaires (91.4 %) were completed for the analyses. Of 148 women, 141 (95.3 %) had menopausal symptoms. The most common and most severe menopausal symptom was muscle and joint pains (84.5 % and 23.0 %, respectively). The majority of the women understood correctly regarding knowledge about menopause issue and daily life during menopause (80.6 % and 89.2 %, respectively). (24)

In 1999, Shin HS, Studied, a study, knowledge of menopause, menopausal management among middle aged women. This descriptive study showed that. The mean score of knowledge of menopausal was 0.68, (0.21-0.71). The mean score of menopausal management was 2.26, (1.35-3.18). In relation between social demographic and menopausal knowledge there were significant differences in the health condition, family members, and marital state. In the menopausal management there was significant differences in the marital state. (25)

In 2000, Sommer B, studied, attitudes toward menopause and aging across ethnic/racial groups, This studies showed that Afri-American women were significantly more positive in attitude. The least positive groups were the less acculturated Chinese American and Japanese American women. Menopausal status was not a consistent predictor of attitude across ethnic groups.(26)

In 2002, Papini DR, studied, attitude toward menopause among married middle-aged adults. This studies showed that. Wives expressed a more positive attitude toward menopause than their husbands, and wives reported experiencing more menopausal symptoms than their husbands perceived them as having. Post-menopausal women expressed a more positive attitude toward menopause than perimenopausal women or women who had experienced surgical menopause. For both men and women, a positive attitude toward menopause was associated with women who reported fewer menopausal symptoms. (27)

In 2006, Loutfy F, Studied, women’s perception and experience of menopause: a community-based study in Alexandria, Egypt.This cross-sectional study

showed that The most frequently recalled symptoms were tiredness (96.0 %), headache (95.1 %), hot flushes (90.7 %), skin wrinkles (90.7 %) and decreased sexual desire (89.1 %). About 91 % of women had never heard about hormone replacement therapy; 42.7 % would expose their body to the sun; 12.4% were moderately active the year before menopause. Multiple regression analysis indicated that women's knowledge about menopause was related to marital status, education and employment status. Practices were related to pattern of menopause, age of menopause and income. (28)

In 2006, Baig LA, Karim SA, studied, age at menopause, and knowledge of and attitude to menopause, of women in Karachi, Pakistan. This studies showed that sources of knowledge about menopause included relatives (35 %), television (18%), neighbours (17 %), friend (17 %) and health-care providers (14 %). (29)

CHAPPER III
MATERIALS AND METHODS

Research design

This research was a retrospective survey research which studied factors associated with decision to postmenopausal woman in rural of Sakhonnakorn Province.

Population and Samples

The populations of this study were females aged 45-70 years old. The sample were 115 postmenopausal women who live at Vanonnivas District in Sakhonnakron Province. The samples were adequate and represented women in rural area of North eastern part of Thailand.

Sample size and Sampling technique

The following formular was used for calculating the sample size by Daniel 's formular. (30)

$$n = \frac{Z^2 \alpha/2 \, (pq)}{d2}$$

n = sample size

p = proportion of level of knowledge about menopause 78.9 % = 0.789(23)

Z = standard normal deviation at 0.05=1.96

d = allowable error in this study 10% of 78.9% =0.0789

q = (1-p) = 0.211

$$n = \frac{(1.96)(1.96)(0.789)(0.211)}{(0.0789)(0.0789)}$$

$$= 103$$

In this study, 10 % of number of sample were added for incomplete or lost data over all, the sample size of this study was 114 postmenopausal woman.

Instruments

The Instruments of this study was questionnaires which was constructed according to the objective of study. They contained 4 parts i.e.:

Part 1 The demographic characteristics of the post menopausal woman.

Part 2 Knowledge about menopause. There were 15 questions. Every correct answer would get 1 score. The total knowledge scores was then categorized into 3 levels by using mean ± standard deviation as follow:

Good Level : The score was more than 10.5

Fair Level : The score was 7.5-10.5

Low Level : The score was less than 7.5

Part 3 Attitude toward menopause. There were 10 questions. The questions included have both positive and negative questions. The method to give the score was follow: (30, 31)

Altitude about menopause

	Positive question	Negative question
Strongly agree	4	1
Agree	3	2
Disagree	2	3
Strongly disagree	1	4

The total attitude scores was categorized into 3 levels

Good Level : The score was more than 3.4

Fair Level : The score was 2.8-3.4

Poor Level : The score was less than 2.8

Part 4 The self care post menopausal woman. There were 10 questions on the details of self care which get the of 1 and 0 respectively.

Pre- testing of the Instrument

Content Validity

Questionnaires were tested the accuracy of language used, context, and objective coverage. It was submitted and examined by three experts. Improvement of questionnaires was done before applying in this study.

Reliability

The improved questionnaires were used in pilot study of 40 who shared similar characteristics with the subject of the present study. Analysis to confirm the reliability by Conbach's alpha co-efficient was then done.

The reliability of the questions about knowledge about post menopausal woman was 0.78 and about attitude toward postmenopausal woman was 0.68.

Data Collection procedure

Data collection procedure are conducted in the following sequences.

1. A letter from the Faculty of Graduate Studies, Mahidol University, will be sent to committee on Human Rights Related to Researches Involving Human Subjects faculty of Medicine, Ramathibodi Hospital, Mahidol University, to srk documentation proof of Ethical clearance Committee on Human Right.

2. The researcher will interview post menopausal woman who meet the selection criterial at Srivichai Subdistrict Vanonnivas District Sakonnakorn Province until the desired number of subjects is covered.

3. The researcher will check the questionnaires for completeness of data.

4. Data analysis.

Data analysis

Data was analyzed by SPSS V.14 for window (Statistical Package for the Social Science):

1. Descriptive statistics used to described the results of demographic characteristics and outcomes. It is presented in term of numbers, percentage, mean and standard deviation.

2. Analytical statistics used to test for association between independent variables and dependent variables included Chi-square test and Peason's Product Moment Correlation Coefficient test.

3. $\alpha = 0.05$

CHAPTER IV
RESULTS

This research was aimed to study knowledge, attitude and self care of postmenopausal women in the rural area in Northeastern Region of Thailand. The survey was done during 15th March, 2008 – 15th April, 2008 by interview 115 postmenopausal women at Vanonnivas District Sakhonnakorn Province, Thailand.

The results of this research were presented in 6 parts:

1. The demographic characteristics postmenopausal women.
2. Knowledge about menopause.
3. Attitude toward menopause.
4. Symptoms of postmenopausal women
5. Association between demographic factors and attitude toward menopause.
6. Self care for postmenopausal women.

1. The demographic characteristics of the postmenopausal women

(Table 1)

Age: The average age of postmenopausal women was 57.10 ± 3.78 years. Most of them were 56-60 years old (45.2 %).

Marital status: The majority of postmenopausal women were married (77.4 %). Only 22.6 % were widow, divorced or separate.

Number of children: Most of postmenopausal women had more than 4 children (88.7 %). Only 11.3 % had less than 4 children.

Education: The majority of postmenopausal women completed primary school (93.9 %). Only 5.2 % were graduated from college (0.9 %).

Income: The average income was 4,851.10±5,734.86 Baths. Most of them (43.5 %) had incomes between 3,001-5,000 Baths.

Occupation: Most of postmenopausal women (80.9 %) worked in agricultural sector. Only (7.0 %) were house wife.

Occupation of husband: Most husbands of postmenopausal women (85.9 %) worked in agricultural sector.

Source of health insurance: Most of postmenopausal women had health insurance of national universal coverage of health care (90.5 %).Only 9.6% had medical benefit as civil servant (9.6 %).

Duration of menopause: Most of postmenopausal women (65.2 %) had cessation of menstruation for 5 years or more.

Table 1 The number and percentage about demographic characteristics of the postmenopausal women.

Demographic Characteristics		**No. (N=115)**	**%**
Age (Years)			
45-50		1	0.9
51-55		39	33.9
56 – 60		52	45.2
61-65		23	20
Mean = 57.10	S.D = 3.78	Min = 50	Max = 69
Marital status			
Single		1	0.9
Married		89	77.4
Widow / Divorced / Separate		25	21.7
Number of Children			
0		1	0.9
1-2		2	1.7
3-4		10	8.7
>4		102	88.7

Table 1 The number and percentage about demographic characteristics of the postmenopausal women. (cont.)

Demographic Characteristics	**No. (N=115)**	**%**
Occupation:		
Agriculture	93	80.9
Employer	3	2.6
Merchant	6	5.2
House wife	8	7.0
Government officer	5	4.3
Occupation of husband(no husband=1)		
Agriculture	98	85.9
Employer	6	5.3
Merchant	3	2.7
Government officer	7	6.1
Education		
Primary school	108	93.9
High school/College	1	0.9
University	6	5.2
Incomes (Baths)		
<3,000	47	40.9
3,001 – 5,000	50	43.5
5,001 – 10,000	6	5.2
10,001 – 20,000	7	6.1
20,001 – 30,000	3	2.6
>30,001	2	1.7
Mean = 4,851.10 S.D = 5,734.86	Min = 1,450	Max = 32,000

Table 1 The number and percentage about demographic characteristics of the postmenopausal women. (cont.)

Demographic Characteristics	**No. (N=115)**	**%**
Source of health insurance:		
Universal coverage of public health care	104	90.4
Civil servant health scheme	11	9.6
Duration of menopause		
1-5 years	40	34.8
>5 years	75	65.2

2. Knowledge about menopause

2.1 Level of knowledge about menopause: Most of the women (38.8 %) had low or fair level of knowledge, 23.4 % of postmenopausal women had good knowledge. Mean and standard deviation of the score of knowledge was 8.3 ± 2.77. (Table 2)

Table 2 Number and percentage of postmenopausal women in rural area classified by level of knowledge about menopause.

Level of knowledge about menopause (Total score = 15)	**No. (N=115)**	**%**
Good (score ≥10.5)	27	23.4
Fair (score 7.5 – 10.5)	44	38.3
Low (score <7.5)	44	38.3
Mean = 8.3 S.D =2.77 Min = 1 Max = 15		

2.2 Source of knowledge about menopause: Most of them received (38.3 %) knowledge or advice from friends, from physician (21.7 %). Nineteen percent of postmenopausal women responded that they received knowledge about menopause from television or radio. (Tables 3)

Table 3 Number and percentage of postmenopausal women classified by knowledge bout menopause. (N=115)

Source of knowledge	**No.**	**%**
Husband / Family	6	5.2
Health personal	25	21.7
television or radio	22	19.1
Friends	44	38.3
Newspaper / magazine	18	15.6

***** One women can give more than one choice.

2.3 Items of knowledge

The items of knowledge that women could answer correctly were the item about menopausal physiologic change (82.6 %), natural signs and symptoms of menopause (78.9 %), and the definition of menopause (73.0 %). Their knowledge was still low about fever among post menopause women (18.3 %), the symptoms of frequency in urination and stress incontinence (26.1 %), and risk of pregnant among postmenopausal women (38.3 %).(Table 4)

Table 4 Number and percentage of correct answers responded by postmenopausal women.

Question	Corrected answer		
	No (115)	%	Level
1. Physiologic change of menopause is that ovaries stop producing sex hormones.	95	82.6	Good
2. Signs and symptoms of menopause occur naturally.	90	78.9	Fair
3. Menopause means cessation of menstruation for 12 months or more consecutively.	84	73.0	Fair
4. Decreased estrogen result in wringle in skin and flabby breast.	83	72.2	Fair
5. Postmenopausal women should check for lump in her breast regularly.	79	68.7	Fair
6. Postmenopausal women experiences hot flash in throat face and neck. Excessive sweating also occurs.	74	64.3	Fair
7. Decreased estrogen production increases risk of osteoporosis and fractures.	73	63.5	Fair
8. Postmenopausal women are vulnerable to vaginal infection due to the thinness of vaginal mucosa which decreases the protection of infection.	67	58.3	Low
9. Decreased estrogen result in feeling exhausted, depressed, and insomnia.	61	53.0	Low

Table 4 Number and percentage of correct answers responded by postmenopausal women. (cont.)

Question	Corrected answer		
	No (115)	%	Level
10. Postmenopausal women will feel pain during intercourse because of lack of lubricates from vagina discharge.	56	48.7	Low
11. Feeling angry or upset are more frequent among postmenopausal women because they had psychotic problem.	54	47.0	Low
12. Postmenopausal women can be pregnant after intercourse.	44	38.3	Low
13. Postmenopausal women have the symptoms of frequency in urination and stress incontinence.	30	26.1	Low
14. Decrease estrogen production results in prolapse of vagina and uterus.	32	27.8	Low
15. Fever is main cause of symptoms of hot flash and occurred in every postmenopausal women.	21	18.3	Low

2.4 The association between demographic characteristics and level of knowledge about menopause

Only marital status was found to be a factors of significant association with knowledge about menopause ($p<0.02$). Single or widowed or divorced women seemed to have better knowledge about menopause there married ones. Only 15 % of single or widowed or divorced women had low level of knowledge compared to 44.9 % of married women. There was no significant association between age, number of children, occupation**,** occupation of husband, source of health insurance and incomes and level of knowledge. (Table 5)

Table 5 The association between demographic characteristics and level of knowledge about menopause.

	Level of knowledge							
characteristics	**Good N=27 No (%)**	**Fair N=44 No (%)**	**Low N=44 No (%)**	**Total N=115 No (%)**	**X^2**	**df**	**r**	**P-value**
Ages (Years)							0.11	0.12
Marital status								
Married	17(19.1)	32(36.9)	40(44.9)	89(100)	8.35	2	-	0.02*
Single/widow/ Divorce/Separate	10(38.4)	12(46.2)	4(15.4)	26(100)				
No. of children							0.01	0.95
Occupation:								
Agriculture	23(24.7)	33(35.5)	37(39.8)	93(100)	1.60	2	-	0.45
Non agriculture	4(18.2)	11(50.0)	7(31.8)	22(100)				
Occupation of husband								
Agriculture	16(20.5)	29(37.2)	33(42.3)	78(100)	2.02	2	-	0.36
Non agriculture	10(27.7)	15(41.7)	11(30.6)	36(100)				
Education								
Primary	26(24.3)	39(36.4)	42(39.3)	107(100)	5.9	2	-	0.05
High school/ College/University	1(12.5)	5(62.5)	2(25.0)	8(100)				
Incomes							0.15	0.55

* $p<0.05$

Table 5 The association between demographic characteristics and level of knowledge about menopause. (cont.)

	Level of knowledge							
characteristics	**Good N=27 No (%)**	**Fair N=44 No (%)**	**Low N=44 No (%)**	**Total N=115 No (%)**	**X^2**	**df**	**r**	**P-value**
Source of health insurance:								
Universal coverage of public health care	24(23.0)	40(38.5)	40(38.5)	104(100)	0.1	2	-	0.95
Civil servant health scheme	3(27.2)	4(36.4)	4(36.4)	11(100)				
Duration of menopause							-0.02	0.96

3. Attitude about menopause

3.1 Level of attitude toward menopause: Most of postmenopausal women (67.0 %) had fair level of attitude. Only 0.9 % of postmenopausal women had good level of attitude. Thirty two point two had poor level of attitude toward menopause. (Table 6)

Table 6 Number and percentage of postmenopausal women classified by attitude level toward menopause.

Level of Attitude (Total score =4)	**No. (N=115)**	**%**
Good (score ≥3.4)	1	0.9
Fair (score 2.8 -3.4)	77	67.0
Poor (score < 2.8)	37	32.2
Mean = 2.81 S.D = 0.29 Min = 2.1	Max = 3.4	

3.2 Items of attitude

The items of attitude toward menopause that women could answers menopause result in no risk of pregnancy (3.41±0.88), menopause is one event occurring deep a time in life and had effects on health (3.03±0.92), and menopause is natural phenomenon women experienced by every women. Poor attitude toward menopause was found when they were asked about comparison of menopause to aging (2.24±0.96) that hormonal supplements are necessary for all postmenopausal women (2.49±0.91) and menopause is comparable to being sick or ill (2.61±1.12) (Table7)

Table 7 Number and percentage of postmenopausal women about attitude classified by attitude statement. (N=115)

Statements	Mean± SD (%)	Level
1. Menopause result in no risk of pregnancy.	3.41±0.88	Good
2. Menopause is one event occurring deep a time in life and had effects on health.	3.03±0.92	Fair
3. Menopause is natural phenomenon women experienced by every women.	2.97±1.10	Fair
4. When menopause occurs the women should visit doctor for advice.	2.90±0.94	Fair
5. Menopause signifies loosing of femininity.	2.88±1.04	Fair
6. Menopause had adversed effects on health and well being.	2.87±1.10	Fair
7. Menopause effects emotion by increasing frequency in feeling upset and angry.	2.74±1.29	Low
8. Menopause is comparable to being sick or ill.	2.61±1.12	Low
9. Taking hormonal supplest in necessary for menopausal women.	2.49±0.91	Low
10. Menopause signifies ageing.	2.24±0.96	Low

3.3 The association between demographic characteristics and level of attitude. (table 8)

There was no significant association between age, marital status, number of children, occupation**,** occupation of husband, source of health insurance and duration of menopause. (Table 8)

Table 8 The association between demographic characteristics and level of attitude toward menopause.

	Level of attitude						
Demographic characteristics	**Good/Fair N=78 No (%)**	**Low N=37 No (%)**	**Total N=115 No (%)**	**X^2**	**df**	**r**	**P-value**
Ages (Years)						-0.02	0.72
Marital status							
Married	64(71.9)	25(28.1)	89(100)	3.0	1	-	0.83
Single/widow/Divorce/ Separate	14(53.8)	12(46.2)	26(100)				
No. of children						-0.07	0.99
Occupation:							
Agriculture	67(72.0)	26(28.0)	93(100)	3.96	1	-	0.13
Non agriculture	11(50.0)	11(50.0)	22(100)				
Occupation of husband							
Agriculture	54(70.1.1)	23(29.9)	77(100)	0.22	1	-	0.64
Non agriculture	24(64.9)	13(35.1)	37(100)				
Education							
Primary	73(67.0)	36(33.0)	109(100)	0.70	1	-	0.37f
High school/ College/University	5(83.3)	1(6.7)	6(100)				
Incomes						-0.07	0.32

f =Fisher's Exact Test

Table 8 The association between demographic characteristics and level of attitude toward menopause. (cont.)

	Level of attitude						
Demographic characteristics	**Good/Fair N=78 No (%)**	**Low N=37 No (%)**	**Total N=115 No (%)**	**X^2**	**df**	**r**	**P-value**
Source of health insurance:							
Universal coverage of public health care	73(70.2)	31(29.8)	104(100)	2.79	1	-	0.94f
Civil servant health scheme	5(45.5)	6(54.5)	11(100)				
Duration of menopause						0.12	0.74

f = Fisher's Exact Test

4. Symptoms of postmenopausal women

Symptoms: The most common symptoms that postmenopausal women experienced were insomnia (72.2 %), irritability (53.0 %), about (20.0 %), urinary incontinence vaginal and bone fracture (14.8 %). (Table 9)

Table 9 Number and percentage of postmenopausal woman who had sings and symptoms. (N=115)

Sing and Symptoms	Yes No. (%)
1. Insomnia	83(72.2)
2. Irritability	61(53.0)
3. Forgetfulness	59(51.3)
4. Depression	45(39.1)
5. Hot flushes	40(34.8)
6. Vaginal pain	35(30.4)
7. Stress incontinence	23(20.0)
8. Vaginal burning	18(15.7)
9. Bone fracture	17(14.8)
10. Constipation	5(4.3)

5. Self care of postmenopausal women

The self care of postmenopausal women experienced were eighty six percent tolerate of insomnia, take self care medicine(9.7 %), and visit of health personnel (3.6 %). Most of them (85.2 %) were tolerate of Irritability, tried to control their emotion (14.8 %). For stress incontinence took self care medicine (13 %), exercise the pelvic floor (8.7 %), and tolerate (78.3 %). Bone fracture visit of health personnel (76.5 %), self care medicine (17.6 %), and tolerate (5.9 %). Eighty five point seven percent of postmenopausal women who self care vagina pain tolerate, and took self care medicine (14.3 %).Self care who has constipation were tolerate (80.0 %), took of self medicine (20.0 %) (table10)

Table10 Number and percentage self care of postmenopausal woman who had sings and symptoms.

Practice when Symptoms occur	Tolerate No. (%)	Self care No. (%)	Health personnel No. (%)	Total No. (%)
1.Insomnia	72(86.7)	-self care medicine 8(9.7)	3(3.6)	83(100)
2.Irritability	52(85.2)	-control of emotion 9(14.8)	0(0)	61(100)
3.Forgetfulness	46(78.0)	-self care medicine 6(10.2)	7(11.8)	59(51.3)
4.Depression ,anxiety	9(20.0)	36(80.0) -control of emotion 8(17.8) -Talk to friends/family 20(44.4) -Watch television, Listen to music8(17.8)	0(0)	45(100)
5.Hot flushes	30(75.0)	10(25.0) -Take showers frequently8(20.0) - Turn on fan or air-conditioner 2(5.0)	0(0)	40(34.8)
6.Vaginal pain	30(85.7)	-self care medicine 5(14.3)	0(0)	35(30.4)
7.Stress incontinence	18(78.3)	5(21.7) - Exercise pelvic floor muscle 2(8.7) -self care medicine 3(13.0)	0(0)	23(100)
8.Vaginal burning	12(66.7)	-self care medicine 5(27.8)	1(5.5)	18(100)
9.Bone fracture(age≥45)	1(5.9)	-self care medicine 3(17.6)	13(76.5)	17(100)
10.Constipation	4(80.0)	-self care medicine 1(20.0)	0(0)	5(100)

6. Practice in health promotion and prevention of disease among postmenopausal women

Most of post menopausal women practiced health promotion and prevention of disease by diet control (64.5 %), drinking water 8 glass/day or more (60.9 %), and exercise (30.4 %). They self examined for breast mass (31.3 %) and had screening CA cervix (47.8 %). (Table11.)

Table 11 Number and percentage of practice in health promotion and prevention of disease among postmenopausal women.

Promotion and Prevention	No.	%
Diet control		
Yes	73	64.5
No	42	35.5
Drinking water(glass/day)		
1-7	45	39.1
>8	70	60.9
Exercise		
No	80	69.6
Yes	35	30.4
Breast examination		
No	79	68.7
Yes	36	31.3
Screening CA cervix		
No	60	52.2
yes	55	47.8

CHAPTER V
DISCUSSION

The discussion of this retrospective research will be divided into 2 parts as follow:

Part I: Research methodology

Part II: Result of the study

Part I: Research methodology

1.1 Research design

This research is a retrospective study. Descriptive is a type of quantitative study that falls under the broad heading of descriptive quantitative research. This type of research involves either identifying the characteristic of an observe phenomenon or exploring possible correlations among two or more phenomenon. In every case, descriptive research examines a situation as it is. It dose not involve changing or modifying the situation under investigation, nor is it intended to detect cause-and-effect relationships. The problem of descriptive study is that one must first to observe and carefully describe the phenomena. Accurate description requires the development of specialized research skills. Selection and use of these proper samples also requires specialized skills (32).

The present research was a descriptive study. The objectives of the study is to determine to level of knowledge, level of attitude toward menopause, self-care and to study of Association between demographic characteristics and knowledge and attitude toward menopause among postmenopausal women in rural area of Sakhonnakorn Province North eastern part of Thailand.

1.2 Population and sample

The populations of this study were females aged 45-70 years old. The sample were 115 postmenopausal women who live at Vanonnivas District in Sakhonnakron Province, during March 2008 to April 2008. The minimal sample size

was 103 and 10 percent were added for data loss or incomplete records. Total sample size was equal to 115 women and it is adequate for analysis to meet the objective.

1.3 Research instrument

The researcher developed an instrument from the review of the related literatures. The questionnaires were validated by three experts and were tried out with a group of 40 subjects who had characteristic similar to those of the subjects in the present study. The reliability of the test of knowledge on menopause was equal to 0.78 while that of the attitude towards menopause was 0.68. Therefore, it could be concluded that both parts of questionnaire were reliable enough for the objectives of the present research.

1.4 Data collection

The research used the interview method for data collection. This method was a good data collection method as some women don't understand each question but the interview helped them understand more clearly the questions in the questionnaire with the help of coordinators, The researcher had an appropriate amount of time to collect data in each subject (20-30 minutes). Thus the results the data collection were correct and complete in this research.

Part II : Result of the study

2.1 Objective 1st. Level of knowledge, attitude toward menopause among postmenopausal women in rural area

Level knowledge about menopause

This study found that most of with postmenopausal women had fair level of knowledge (77.6%).This is in contrast the study of Upakarakul L(21) which studied in Muang District of Khon Kaen Province and found that level of knowledge of menopause was at high level and the study of Chaopotong P(24) which studied in Bangkok was found that the majority of the women understood correctly about menopause and daily life during menopause (80.6% and 89.2%, respectively).This may be due to the differences in population characteristics. Bangkok and Khon Kaen

are urban areas with a higher level development. Women in the urban areas tend to have higher education and more available source of knowledge (television, radio, magazine, internet etc.)

In this study most of postmenopausal women live in rural area (100 %) and 94.8 % completed primary school and 80.9 %. Regarding source of knowledge about menopause, most of them (38.3 %) got knowledge from friends.

The study of Choi NY (22) in South Korea found that high score of knowledge of menopause, the higher score of self-care. The score of knowledge was the highest in the women group 45-50 years old, with higher education, and high number of family members. South Korea is more developed than Thailand.

This study found that most of the postmenopausal women had source of knowledge about menopause from television at low level (19.1 %). This is in accordance with the study of Baig LA (29) in Karachi, Pakistan who found that source of knowledge about menopause included relatives (35 %), television (18 %), neighbours (17 %), friends (17 %) and health-care providers (14 %).

In this study postmenopausal women knew well about physiologic change (82.6 %), natural signs and symptoms of menopause (78.9 %), and the definition of menopause (73.0 %). Their knowledge was still low about fever among post menopause women (18.3 %), the symptoms of frequency in urination and stress incontinence (26.1 %), and risk of pregnancy among postmenopausal women (38.3 %). These aspects should be emphasized to improve knowledge of menopause among postmenopausal women.

Level of attitude toward menopause

This study found that most of the postmenopausal women had fair level of attitude (67.0 %). This is in accordance with the study of Sommer B (26), who found that Afri-American women were significantly more positive in attitude toward menopause. The least positive group was the less acculturated Chinese American and Japanese American women. Menopausal status was not a consistent predictor of attitude across ethnic groups, Papini DR (27) found that postmenopausal women expressed a more positive attitude toward menopause than perimenopausal women or

women who had experienced surgical menopause. Women in our study were totally postmenopause and of Asian origin.

In this study most postmenopausal women had good attitude toward menopause about adverse effects on health and well being (98.0 %), that menopause is natural phenomenon which every women experienced, (87.0 %), and menopause is one event occurring during a time in life and had effects on health (85.5). Poor attitude toward menopause was found when they were asked about comparison of menopause to aging (64.5 %), that hormonal supplements are necessary for all postmenopausal women (68.5 %) and about advice of doctors (68.8 %).

To improve attitude toward menopause in these aspects, knowledge and advice about menopause should be provided by more appreciate source of knowledge such as by community radio or from health personnel and hospital staff. Improvement of source of information especially in mass media with content that are easy to understand and make women realized the important aspects about menopause and self- care.

2.2 Objective 2nd Self care about menopausal symptoms among postmenopausal women in rural area

Self care about menopausal symptoms among postmenopausal women

This study found that most of postmenopausal women had low level of self care (29 %). This is in contrast with the study of Choi NY (22) in South Korea, who found that in the score of management of postmenopause was the highest in self control category. This may also be due to the differences in population characteristics. Although of the women in the study completed primary school education level (94.8 %) but their society is more advanced than Thai society.

2.3 Objective 3rd Association between demographic characteristics and knowledge and attitude toward menopause among postmenopausal women in rural area

The association between demographic characteristics and level of knowledge about menopause

This study found that factor which had significantly associated with level of knowledge was marital status.

Marital status had significantly association with level of knowledge about menopause. This is in accordance with the study of Shin HS (25) who studied in Pusan, South Korea and found that in relation between social demographic characteristics and menopausal knowledge there were significant differences in the health condition, family members, and marital status.

The study of Loutfy F (28) in Alexandria, Egypt found that women's knowledge about menopause was related to marital status. It is also found that their population had adequate marital status. This result may be due to the effect of husband who is also a support source of knowledge of menopause.

2.4 The association between demographic characteristics and level of attitude toward menopause

This study found that these was no significantly association between demographic characteristics and level of attitude toward menopause. This is in contrast to the study of Papini DR (27) who found that a positive attitude toward menopause was associated with women who reported fewer postmenopausal symptoms.

CHAPTER VI
CONCLUSION

Menopause is a physiological change which has several effects on the physical and mental health of women. The objectives of this cross-sectional survey research are to study knowledge, attitude and self-care of post menopausal women in the rural area of Sakhonnakorn Province, Thailand. Data was collected by interviewing 115 post menopausal women who live at Vanonnivas District in Sakhonnakorn Province. Descriptive statistics included frequency, percentage, mean and standard deviation. Chi-square test and Pearson's Product Moment Coefficients were used for hypothesis testing of association at the significance level of α=0.05 by using the SPSS V.14 statistical program.

The results of the study showed that mean age of postmenopausal women was 57.10±3.78 years. Most postmenopausal women (94.8 %) completed primary school. Ninety nine point one percent were married and 88.7 % had more than 4 children. Most women were farmers (80.9 %). Their average family income was 4,851±5,734 bath per month. Most (90.4 %) had universal coverage health insurance for health care. Most (65.2 %) had had cessation of menstruation for 5 years or more. Regarding knowledge, most of them (76.6 %) had fair or low level of knowledge about menopause with the mean score of 8.3± 2.77 from 15 question, and 67.0 % had fair or low attitude towards menopause. Twenty nine percent had low level of self-care. Regarding source of knowledge about menopause, most of them (38.3 %) had got knowledge from friends. Other sources of knowledge were less common. The factor which had significant association with level of knowledge of menopause was marital status (α<0.02).

In conclusion, knowledge and attitude of postmenopausal women in the rural area was rather low. Thus knowledge or advice about menopause and self-care should

be provided by more appreciate sources of knowledge such as by community radio or from health personnel and hospital staff, and should be widely disseminated for improving self-care during the postmenopausal period.

Recommendation for Application

1. The information can be used in promoting knowledge and understanding of menopausal women in their physical and mental changes .This can be in the form of

1.1 Classes to teach about physical and mental changes, menopausal symptoms and proper health behavior for menopausal women who come to the Menopause clinic.

1.2 Information sheet, pamphlets, community radio or manuals on physical, mental and social changes with practice to self care the menopausal symptoms should be provided. This can be taken back home to read as a review.

2. Encourage postmenopausal women to form a group among which ideas, information and experience are shared, suggest and console one another regarding their physical, mental and social problem and in which they care help each other.

Recommendation for Further Research

1. Establish a workable guideline for women to get information about menopause and self care.

2. Study knowledge, attitude and self care of post menopausal women in different geographic areas and different occupations.

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APPENDIX

แบบทดสอบที่.....

การวิจัยเรื่อง ความรู้ ทัศนคติและการดูแลตนเองของสตรีวัยหมดประจำเดือนตาม ธรรมชาติในชนบท ตำบลศรีวิชัย อำเภอวานรนิวาส จังหวัดสกลนคร

คณะแพทย์ศาสตร์โรงพยาบาลรามาธิบดี

เรื่อง ขอความร่วมมือในการตอบแบบสอบถาม

เรียน ท่านผู้ตอบแบบสอบถาม

เนื่องด้วยข้าพเจ้า นางธิติมา ตั้งพิมลจิตต์ นักศึกษาหลักสูตรวิทยาศาสตร์มหาบัณฑิต คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี กำลังทำวิทยานิพนธ์เรื่องความรู้ ทัศนคติและการดูแลตนเองของสตรีวัยหมดประจำเดือนตามธรรมชาติในชนบท ตำบลศรีวิชัย อำเภอวานรนิวาส จังหวัดสกลนคร ท่านเป็นบุคคลสำคัญยิ่งในการให้ข้อมูลครั้งนี้จึงขอความร่วมมือในการตอบแบบสอบถามคำตอบที่ได้ผู้วิจัยจะเก็บเป็นความลับ และจะไม่มีผลต่อท่านทั้งทางตรงและทางอ้อมแต่จะสรุปผลการศึกษาที่เป็นประโยชน์ต่อส่วนรวม

ผู้วิจัยขอขอบคุณทุกท่านที่ให้ความร่วมมือในการตอบแบบสอบถาม ณ ที่นี้ด้วย

ธิติมา ตั้งพิมลจิตต์
นักศึกษาปริญญาโท สาขาการเจริญพันธุ์และการวางแผนประชากร
มหาวิทยาลัยมหิดล

แบบสัมภาษณ์

เรื่อง : ความรู้ ทัศนคติและการดูแลตนเองของหญิงวัยหมดประจำเดือนตามธรรมชาติ ในสตรีชนบท ต.ศรีวิชัย อ. วานรนิวาส จ. สกลนคร

<u>คำแนะนำในการสัมภาษณ์</u>

1. แบบสัมภาษณ์นี้ใช้สัมภาษณ์สตรีที่หมดประจำเดือนเกิน 1 ปี และอายุไม่เกิน 70 ปี
2. แบบสัมภาษณ์นี้แบ่งเป็น 3 ส่วนดังนี้

ส่วนที่ 1 ข้อมูลด้านประชากร พฤติกรรมสุขภาพ เศรษฐกิจและสังคม	10	ข้อ
ส่วนที่ 2 ข้อมูลด้านความรู้เกี่ยวกับภาวะหมดระดู	15	ข้อ
ส่วนที่ 3 ข้อมูลด้านทัศนคติเกี่ยวกับการหมดประจำเดือน	10	ข้อ
ส่วนที่ 4 ข้อมูลการปฏิบัติในการดูแลสุขภาพตนเองเมื่อหมดระดู	20	ข้อ

3. ขอความร่วมมือในการตอบคำถามตามแบบสัมภาษณ์นี้ โดยแจ้งให้ผู้ตอบข้อมูลทราบว่าข้อมูลที่ได้นี้จะเก็บไว้เป็นความลับเพื่อใช้ในการศึกษาเท่านั้น ดังนั้นขอให้ตอบตามความเป็นจริงและโปรดตอบคำถามทุกข้อ

ส่วนที่ 1 ข้อมูลทั่วไป

ให้ทำเครื่องหมาย ✓ ใน ( ) หน้าข้อความที่ตรงกับท่านมากที่สุด

ข้อมูลทั่วไป

1. ขณะนี้ท่านมีอายุเท่าใด อายุ..... ปี

2. ท่านมีสภาพสมรสอะไร

( ) คู่ ( ) โสด ( ) หม้าย ( ) หย่า ( ) แยกกันอยู่

3. การศึกษาสูงสุด

( ) ไม่ได้เรียน ( ) ประถมศึกษา

( ) มัธยมศึกษาตอนต้น ( ) มัธยมศึกษาตอนปลาย

( ) ประกาศนียบัตร ( ) อนุปริญญา

( ) ปริญญาตรี ( ) อื่นๆ ระบุ.....

4.ปัจจุบันท่านมีอาชีพอะไร

( ) เกษตรกรรม ( ) ค้าขาย

( ) รับจ้าง ( ) แม่บ้าน/ทำงานบ้าน

( ) ข้าราชการ/รัฐวิสาหกิจ ( ) อื่นๆ ระบุ.....

5. สามีท่านมีอาชีพอะไร

( ) เกษตรกรรม ( ) ค้าขาย

( ) รับจ้าง ( ) แม่บ้าน/ทำงานบ้าน

( ) ข้าราชการ/รัฐวิสาหกิจ ( ) อื่นๆ ระบุ.....

6.รายได้รวมต่อเดือนของทุกคนในครอบครัวท่านประมาณ.....บาท/เดือน

7.ท่านนับถือศาสนาอะไร

( ) พุทธ ( ) อิสลาม

( ) คริสต์ ( ) อื่นๆระบุ.....

8.ท่านคลอดบุตรกี่คน .....คน บุตรที่มีชีวิตในปัจจุบัน.....คน

9. ท่านมีสิทธิในการใช้บริการสุขภาพประเภทใดบ้าง (ตอบได้มากกว่า 1 ข้อ)

( ) บัตรประกันสุขภาพถ้วนหน้า (บัตรทอง 30บาท)

( ) บัตรประกันสังคม

( ) มีสิทธิเบิกค่ารักษาพยาบาล(ข้าราชการ/รัฐวิสาหกิจ)

( ) ประกันสุขภาพกับบริษัทเอกชน (ประกันชีวิต)

( ) ไม่มีสิทธิใดๆเลย จ่ายค่ารักษาพยาบาลเองทั้งหมด

( ) อื่นๆระบุ.....

10. ท่านได้รับความรู้เกี่ยวกับวัยหมดประจำเดือนจากทางด้านใดบ้าง (ตอบได้มากกว่า 1 ข้อ)

( ) หนังสือพิมพ์ ( ) วารสารต่างๆ

( ) รายการวิทยุ ( ) รายการโทรทัศน์

( ) เพื่อน ( ) เจ้าหน้าที่สาธารณสุข

( ) สมาชิกในครอบครัว ( ) อื่นๆระบุ.....

ส่วนที่ 2 ความรู้เกี่ยวกับการหมดประจำเดือน

คำถาม	ใช่	ไม่ใช่	ไม่ทราบ
1.การหมดประจำเดือนคือการไม่มีประจำเดือนติดต่อกันเป็นเวลา 12 เดือน			
2.การหมดประจำเดือน เกิดเพราะรังไข่ผลิตฮอร์โมนเพศลดลง			
3.การเปลี่ยนแปลงของหญิงวัยหมดประจำเดือนเป็นการเปลี่ยนแปลงตามธรรมชาติ			
4.หญิงวัยหมดประจำเดือน มักมีอาการร้อนวูบวาบตามตัว ใบหน้า เกิดเนื่องจากอาการครั่นเนื้อครั่นตัวจากการมีไข้			
5.หญิงวัยหมดประจำเดือน มักมีอาการร้อนซู่ซ่าตามลำคอ ใบหน้า และมีเหงื่อออกมากกว่าปกติ			
6.หญิงวัยหมดประจำเดือน จะเจ็บปวดเมื่อมีเพศสัมพันธ์เพราะช่องคลอดแห้งเนื่องจากสารหล่อลื่นลดลง			
7.หญิงวัยหมดประจำเดือน เกิดการติดเชื้อทางช่องคลอดได้ง่าย เพราะผนังช่องคลอดบางและมีความต้านทานต่อเชื้อโรคลดลง			
8.หญิงวัยหมดประจำเดือน สามารถตั้งครรภ์ด้วยตนเองได้			
9.หญิงวัยหมดประจำเดือน จะมีปัสสาวะบ่อย และมีปัสสาวะเล็ดเมื่อไอหรือจาม			
10.การลดลงของฮอร์โมนเพศ ทำให้ช่องคลอดและมดลูกหย่อนยาน			
11.การลดลงของฮอร์โมนเพศ ทำให้ผิวหนังเหี่ยวย่น เต้านมหย่อนยาน			
12.หญิงวัยหมดประจำเดือน จำเป็นต้องตรวจเต้านม เป็นประจำสม่ำเสมอ			
13.การลดลงของฮอร์โมนเพศทำให้เกิดโรคกระดูกพรุน หรือกระดูกหักได้ง่ายกว่าปกติ			
14.อาการโมโห หงุดหงิดง่าย โกรธง่าย ของหญิงวัยหมดประจำเดือนถือว่าเป็นความผิดปกติทางด้านจิตใจ			
15.ความรู้สึกอ่อนเพลีย เศร้าซึม นอนไม่หลับ มีสาเหตุมาจากฮอร์โมนเพศลดลงในหญิงวัยหมดประจำเดือน			

ส่วนที่ 3 ด้านทัศนคติเกี่ยวกับการหมดประจำเดือน

<u>คำชี้แจง</u> แบบสัมภาษณ์นี้มีวัตถุประสงค์เพื่อสอบถามเกี่ยวกับทัศนคติเกี่ยวกับการหมดประจำเดือน ซึ่งจะถามความคิดเห็น ความเข้าใจหรือความรู้สึกของท่าน โดยท่านต้องตอบคำถามที่ตรงกับความคิดเห็น ความรู้สึกหรือความเข้าใจของท่านโดยเลือกคำตอบเพียงคำตอบเดียว

โดยมีคำตอบให้เลือกตอบ ดังนี้

เห็นด้วยอย่างยิ่ง	หมายถึง	ข้อความในประโยคนั้นตรงกับความคิดเห็น ความเข้าใจหรือความรู้สึกของท่านทั้งหมด
เห็นด้วย	หมายถึง	ข้อความในประโยคนั้นตรงกับความคิดเห็น ความเข้าใจหรือความรู้สึกของท่านเป็นส่วนใหญ่
ไม่เห็นด้วย	หมายถึง	ข้อความในประโยคนั้นไม่ตรงกับความคิดเห็น ความเข้าใจหรือความรู้สึกของท่านเป็นส่วนใหญ่
ไม่เห็นด้วยอย่างยิ่ง	หมายถึง	ข้อความในประโยคนั้นไม่ตรงกับความคิดเห็น ความเข้าใจหรือความรู้สึกของท่านเลย

คำถาม	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
ท่านมีความคิดเห็น ความเข้าใจหรือความรู้สึกว่า วัยหมดประจำเดือนเป็นอย่างไร 1. ท่านคิดว่าการหมดประจำเดือนเป็นเรื่องปกติเกิดกับผู้หญิงทุกคน 2. ท่านคิดว่าการหมดประจำเดือนเป็นสัญญาณบอกถึงความแก่ 3. ท่านคิดว่าเมื่อหมดประจำเดือนต้องไปพบแพทย์ 4. ท่านคิดว่าการหมดประจำเดือนเป็นระยะเวลาหนึ่งของการเปลี่ยนแปลงในชีวิตและสุขภาพ 5. ท่านคิดว่าเมื่อหมดประจำเดือนแล้วรู้สึกสูญเสียความเป็นผู้หญิง 6. ท่านคิดว่าเมื่อหมดประจำเดือนทำให้สุขภาพอ่อนแอและไม่แข็งแรง 7. การหมดประจำเดือนทำให้ท่านเปลี่ยนแปลงทางด้านอารมณ์เช่นหงุดหงิดง่าย โกรธ โมโหง่าย 8. ท่านคิดว่าเมื่อหมดประจำเดือนต้องกินฮอร์โมน 9. ท่านคิดว่าการหมดประจำเดือน เรียบเหมือนการเจ็บป่วยหรือเป็นโรค 10. เมื่อหมดประจำเดือนทำให้ท่านไม่วิตกกังวลเกี่ยวกับเรื่องท้อง				

ส่วนที่ 4 การดูแลตนเองของหญิงหมดประจำเดือน

โปรดใส่เครื่องหมาย √ ใน ( ) หน้าข้อความที่ตรงกับแนวการปฏิบัติตัวของท่านมากที่สุด

1.ขณะนี้ท่านไม่มีประจำเดือนนาน.....

2.เมื่อประจำเดือนขาดหายไปนานมากกว่า1 ปี ท่านได้ปรึกษาใครหรือไม่

( ) ไม่ได้ปรึกษา

( ) ปรึกษา ( ) ปรึกษาแพทย์ในโรงพยาบาลหรือคลินิก

( ) ปรึกษาเพื่อนหรือผู้ร่วมงานในวัยเดียวกัน หรือสูงกว่า

( ) อื่นๆระบุ.....

3.เมื่อประจำเดือนขาดหายไปท่านมีอาการร้อนวูบวาบตามตัวหรือไม่

( ) ไม่มี

( ) มี ( ) มากจนทนไม่ได้

( ) ปานกลางพอทนไหว

( ) เล็กน้อย

4.ท่านมีอาการร้อนวูบวาบตามตัว ท่านปฏิบัติตัวอย่างไร

( ) ปรึกษาแพทย์ ( ) อาบน้ำบ่อยๆ

( ) เช็ดตัวด้วยน้ำเย็น ( ) เปิดพัดลม

( ) ปล่อยไว้เฉยๆ ( ) อื่นระบุ.....

5.ปัจจุบันท่านอยู่ด้วยกันกับสามีหรือไม่ (ถามเฉพาะผู้ที่มีสภาพสมรส)

( ) อยู่กับสามี

( ) ไม่ได้อยู่กับสามี

6.ถ้าอยู่กับสามี ปัจจุบันท่านยังมีเพศสัมพันธ์กันอยู่หรือไม่

( ) ไม่มี

( ) มี ( ) ความต้องการทางเพศเท่าเดิม

( ) ความต้องการทางเพศลดลง

( ) ความต้องการทางเพศเพิ่มขึ้น

7.สำหรับผู้ที่ยังมีเพศสัมพันธ์

ขณะมีเพศสัมพันธ์ท่านมีอาการเจ็บช่องคลอดหรือไม่

( ) ไม่มี

( ) มี ท่านปฏิบัติอย่างไร

( ) ปล่อยไว้เฉยๆไปปรึกษาแพทย์ แนะนำให้ใช้ฮอร์โมนทดแทน

( ) ไปปรึกษาแพทย์ แนะนำให้ใช้ฮอร์โมนทดแทน

( ) ซื้อยามารับประทานเอง

( ) หลีกเลี่ยงการมีเพศสัมพันธ์

( ) อื่นๆระบุ.....

8.ปัจจุบันท่านมีอาการกลั้นปัสสาวะไม่ได้หรือไม่

( ) ไม่มี

( ) มี มีมานานเท่าใด.....

ท่านปฏิบัติอย่างไร

( ) ปล่อยไว้เฉยๆ

( ) ทดลองฝึกกลั้นปัสสาวะเอง

( ) ซื้อยามารับประทานเอง

( ) บริหารฝีเย็บตามคำแนะนำของเจ้าหน้าที่สาธารณสุข

( ) อื่นๆระบุ.....

9.เมื่อเข้าสู่ภาวะวัยหมดประจำเดือนท่านมีอาการแสบร้อนในช่องคลอดหรือไม่

( ) ไม่มี

( ) มี นานเท่าใด.....

ท่านปฏิบัติอย่างไร

( ) ปล่อยไว้เฉยๆ

( ) ซื้อยามารับประทานเอง

( ) ซื้อยามาเหน็บช่องคลอดเอง

( ) ซื้อยาครีมมาทาช่องคลอดเอง

( ) ปล่อยไว้เฉยๆ

( ) อื่นๆระบุ.....

10.ท่านเคยกระดูกหักหรือไม่

( ) ไม่เคย

( ) เคยถ้าท่านเคยกระดูกหักเกิดขึ้นเมื่อท่านอายุเท่าใด.....

ตำแหน่งที่กระดูกหัก.....

สาเหตุที่ทำให้กระดูกหัก.....

หากท่านมีปัญหากระดูกหัก ท่านปฏิบัติตัวอย่างไร

( ) ไปพบแพทย์

( ) ซื้อยามารับประทานเอง

( ) รักษาโดยการกินยาสมุนไพร ระบุ.....

( ) รักษาโดยวิธีพื้นบ้าน เช่น การใช้น้ำมนต์ วิธีไสยศาสตร์ การนวด

( ) อื่นๆระบุ.....

11.ท่านมีอาการหลงลืมง่าย ลืมเลือนหรือไม่

( ) ไม่มี

( ) มี นานเท่าใด.....ปี

ถ้าอาการหลงลืม ลืมเลือนมีผลกระทบต่อชีวิตประจำวันท่านจะแก้ไขอย่างไร

( ) ไปพบแพทย์

( ) ซื้อยามารับประทานเอง

( ) ปล่อยไว้เฉยๆ

( ) อื่นๆระบุ.....

12.ปัจจุบันท่านมีอาการหงุดหงิด โมโห โกรธง่าย ใจน้อยหรือไม่

( ) ไม่มี

( ) มี เริ่มมีอาการเมื่ออายุเพิ่มมากขึ้น อายุเท่าใด.....ปี

อาการปัจจุบันท่านเป็นอย่างไร

( ) เท่าเดิม

( ) ลดลงกว่าเดิม

( ) มากขึ้นกว่าเดิม

ถ้ามีอาการ ท่านปฏิบัติตัวอย่างไร

( ) นั่งสมาธิ

( ) ควบคุมจิตใจตนเอง

( ) ระบายอารมณ์ โดยวิธี ระบุ.....

( ) ไปพบแพทย์

( ) อื่นๆระบุ.....

13.ปัจจุบันท่านมีความรู้สึกซึมเศร้า ท้อแท้(โดยไม่มีสาเหตุ) หรือไม่

( ) ไม่เคย

( ) เคย ( ) เคยมีอาการนี้ตั้งแต่วัยสาว

( ) เริ่มมีอาการเมื่ออายุเพิ่มมากขึ้น อายุเท่าใด.....ปี

ถ้าความรู้สึกดังกล่าวเป็นปัญหาต่อชีวิตประจำวันของท่าน ท่านปฏิบัติตนอย่างไร(ตอบได้มากกว่า 1ข้อ)

( ) ปรึกษาแพทย์หรือจิตแพทย์

( ) ซื้อยามารับประทานเอง

( ) ออกกำลังกาย

( ) พักผ่อน โดยวิธี.....

( ) ฝึกสมาธิ

14.ปัจจุบันท่านตรวจเต้านมด้วยตนเองตนหรือไม่

( ) ไม่ตรวจ เพราะ.....

( ) ตรวจ ถ้าท่านตรวจท่านปฏิบัติบ่อยเพียงใด

( ) ทุกวัน

( ) ทุกสัปดาห์

( ) ทุกเดือน

( ) ทุกปี

15.ท่านเคยไปตรวจโรคที่คลินิคโรคเฉพาะสตรีหรือไม่ (ตรวจภายใน)

( ) ไม่เคย

( ) เคย ตรวจประจำปี ครั้งสุดท้ายเมื่อใด.....

ตรวจเมื่อมีอาการผิดปกติ ระบุสาเหตุที่มาตรวจ.....

.....

ครั้งสุดท้ายเมื่อใด.....

16.ปัจจุบันท่านดื่มนมหรือไม่

( ) ไม่ดื่ม

( ) เคยดื่มในอดีต ระยะเวลาที่ดื่ม.....ปี

เลิกดื่มมานานกี่ปี.....ปี

( ) ดื่ม ระยะเวลาที่ดื่มนานกี่ปี.....ปี

ความถี่ของการดื่ม ( ) ทุกวัน วันละ1-3แก้ว

( ) ทุกวันมากกว่า 3แก้ว

( ) ไม่แน่นอน ระบุ.....

17.ปัจจุบันท่านเลือกรับประทานอาการประเภทใดบ้าง (ตอบได้มากกว่า 1ข้อ)

( ) ประเภทเนื้อสัตว์ เช่น หมู วัว ปลา ไก่

( ) ประเภทผลิตภัณฑ์จากนม เช่น นมพร่องมันเนย นมเปรี้ยว

( ) ประเภทแคลเซี่ยม เช่น ปลาตัวเล็ก ผักใบเขียว กุ้ง ถั่วเหลือง

( ) ประเภทมีกากใย เช่นผัก ผลไม้

( ) ประเภทเครื่องในสัตว์ เช่น ตับ หัวใจ ลำไส้

( ) ดื่มน้ำอย่างน้อยวันละ.....แก้ว

18. ในเวลา 1 ปีที่ผ่านมา ท่านมีอาการท้องผูกหรือไม่

( ) ไม่มี

( ) มี นานเท่าใด ระบุ.....

ถ้ามีอาการผิดปกติท่านปฏิบัติอย่างไร

( ) ปล่อยไว้เฉยๆ

( ) ซื้อยาระบายมารับประทานเอง

( ) รับประทานผักและผลไม้มากขึ้น

( ) ดื่มน้ำมากกว่าปกติ

( ) ปรึกษาแพทย์

( ) อื่นๆระบุ.....

19.ปัจจุบันท่านออกกำลังกายหรือไม่ (การออกกำลังกายหมายถึง การเคลื่อนไหวร่างกายที่ก่อให้เกิดการเต้นของหัวใจเร็วละแรงขึ้น มีเหงื่อออก เป็นเวลานาน 30 นาที)

( ) ไม่เคยออกกำลังกาย เพราะ.....

( ) ออกกำลังกาย ท่านออกกำลังกายโดยวิธีอะไร ระบุ.....

สัปดาห์ละกี่วัน .....วัน

20.การนอนหลับพักผ่อนวันละประมาณ.....ชั่วโมง

การนอนหลับของท่านแตกต่างจากวัยสาวหรือไม่

( ) ไม่แตกต่าง

( ) แตกต่าง ระบุ.....

ถ้านอนไม่หลับท่านปฏิบัติตัวอย่างไร

( ) ปรึกษาแพทย์ ( ) ซื้อยานอนหลับมารับประทานเอง

( ) ปล่อยไว้เฉยๆ ( ) อื่นๆระบุ.....

BIOGRAPHY

NAME	Miss Titima Tungpimoljit
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