REUFSM
REVISTA DE ENFERMAGEM DA UFSM

UFSM
Rev. Enferm. UFSM - REUFSM
Santa Maria, RS, v. 11, e15, p. 1-19, 2021
DOI: 10.5902/2179769242948
ISSN 2179-7692

Original Article Submission: 03/15/2020 Acceptance: 09/16/2020 Publication: 18/02/2021

Care needs of women in climacteric with hypertension: nurses' work possibilities

Necessidades de cuidado de mulheres no climatério com hipertensão: possibilidades de trabalho do enfermeiro

Necesidades de cuidado de mujeres en el climaterio con hipertensión: posibilidades de trabajo del enfermero

Lara Castilhos[I], Maria Denise Schimith[II], Laís Mara Caetano da Silva[III], Lisie Alende Prates[IV], Nara Marilene Oliveira Girardon-Perlini[V]

Abstract: **Objective**: To understand the care needs of women in climacteric with Systemic Arterial Hypertension (SAH). **Method**: this is qualitative research developed in 21 Family Health Units (FHUs), during April and June 2019. Fifteen women between 40 and 69 years old participated; with a referred diagnosis of SAH, attached to the FHUs and who reported not using hormonal contraceptives. We used semi-structured interviews, followed by the construction and return of narratives, with participatory analysis. **Results**: care needs included management of signs and symptoms; monitoring blood pressure levels, effectiveness, and treatment adherence; guidance on food choices; search for reliable information, and active listening. The perception of the nurse's work referred to individual and punctual care. **Conclusion**: the climacteric is experienced differently and the needs of women show different possibilities for improving care. This identification allows the nurse to develop individualized care and adapted to the demands of women.

Descriptors: Climacteric; Hypertension; Women's health; Nursing; Primary Health Care

Resumo: Objetivo: compreender as necessidades de cuidado de mulheres no climatério com Hipertensão Arterial Sistêmica (HAS). **Método:** pesquisa qualitativa desenvolvida em 21 Unidades de Saúde da Família (USFs), durante abril e junho de 2019. Participaram 15 mulheres com idade entre 40 e 69 anos; com diagnóstico referido de HAS, adstritas às USFs e que referiram não usar anticoncepcionais hormonais. Utilizou-se entrevista semiestruturada, seguida pela construção e devolução de narrativas, com análise participativa. **Resultados:** as necessidades de

[I] Nurse. Master in Nursing. Instituto Federal Catarinense. Santa Rosa do Sul, Santa Catarina, Brazil. E-mail: laracastilhos23@gmail.com - ORCID: https://orcid.org/0000-0003-2845-973X.

II Nurse. Post-doctorate in Nursing /FURG. Professora Adjunta da Universidade Federal de Santa Maria. Santa Maria, Rio Grande do Sul, Brazil. E-mail: ma.denise2011@gmail.com - ORCID: http://orcid.org/0000-0002-4867-4990

III Nurse, Post-doctorate in Public Health Nursing. Adjunct Professor at Universidade Federal de Santa Maria. Santa Maria, Rio Grande do Sul, Brazil. ORCID: https://orcid.org/0000-0001-7596-2333.

IV Nurse, Ph.D. in Nursing, Adjunct Professor at Universidade Federal do Pampa. Uruguaiana, Rio Grande do Sul, Brazil. ORCID: http://orcid.org/0000-0002-5151-0292.

V Nurse, Post-doctorate in Nursing, Associate Professor, Universidade Federal de Santa Maria, Santa Maria, Rio Grande do Sul, Brazil, E-mail: nara.girardon@gmail.com ORCID: 0000-0002-3604-2507

*** Extracted from the dissertation "Care needs of women in climacteric with hypertension: possibilities for nurses to act", Graduate Program in Nursing, Universidade Federal de Santa Maria, 2020.**

cuidado incluíam manejo dos sinais e sintomas; acompanhamento dos níveis pressóricos, efetividade e adesão ao tratamento; orientação sobre escolhas alimentares; busca por informações confiáveis e escuta ativa. A percepção acerca do trabalho do enfermeiro remeteu ao atendimento individual e pontual. **Conclusão:** o climatério é vivenciado de forma distinta e as necessidades das mulheres demonstram diferentes possibilidades de aprimoramento do cuidado. Essa identificação permite que o enfermeiro desenvolva atenção individualizada e adaptada às demandas das mulheres.
Descritores: Climatério; Hipertensão; Saúde da Mulher; Enfermagem; Atenção Primária à Saúde

Resumen: **Objetivo:** comprender las necesidades de cuidado de mujeres en el climaterio con Hipertensión Arterial Sistemica (HAS). **Método:** investigación cualitativa desarrollada en 21 Unidades de Salud de la Familia (USFs), durante abril y junio de 2019. Participaron 15 mujeres con edad entre 40 y 69 años; con diagnóstico referido de HAS, adscritas a las USFs y que dijeron no usar anticoncepcionales hormonales. Se utilizó una entrevista semi-estructurada, seguida por la construcción y devolución de narrativas, con análisis participativa. **Resultados: l**as necesidades de cuidado incluyeron el manejo de señales y síntomas; acompañamiento de los niveles de presión, efectividad y adhesión al tratamiento; orientación sobre elecciones alimentares; búsqueda por informaciones confiables y escucha activa. La percepción acerca del trabajo del enfermero fue sobre el atendimiento individual y puntual. **Conclusión:** el climaterio es vivido de forma distinta y las necesidades de las mujeres demuestran diferentes posibilidades de mejora del cuidado. Esa identificación permite que el enfermero desarrolle una atención individualizada y adaptada a las demandas de las mujeres.
Descriptores: Climaterio; Hipertensión; Salud de la Mujer; Enfermería; Atención Primaria de Salud

Introduction

Women are the largest portion of the Brazilian population, representing 51.7% of the country's total inhabitants.[1] They are also the main users of the Unified Health System (SUS), and such representativeness has required new perspectives in the care focused on their health, aimed at structuring assistance that encompasses them in their entirety. Based on this, the National Policy for Integral Attention to Women's Health (PNAISM) was elaborated,[2] aimed to fill the gaps left by previous policies in certain periods/groups of the female life cycle, for example, women in the climacteric. Climacteric is an endocrine condition, characterized by a progressive decline in estrogen resulting from the depletion of ovarian follicles. This phase comprises the transition between the reproductive and non-reproductive period, appearing between 35 and 40 years old, and it can extend to 65 years old.[3]

PNAISM represented an advance for women's health by incorporating comprehensive care and health promotion as guiding principles, especially for women who experience climacteric, for example, as a subsidy for the elaboration of the Comprehensive Health Care Manual of Women in Climacteric/Menopause. However, health care at this stage of life does not yet cover the desired comprehensiveness, considering that the demands of this group are not always materialized in Primary Health Care (PHC), a center in the Health Care Network (HCN) that would be the most appropriate for this assistance.[4]

Although the advances in the area are notable, given the incipience of this movement within the scope of the Ministry of Health's policies and programmatic actions, the actions of the policies and programs are still centralized in the maternal and child area. Also, the idea persists in society in general, that upon reaching climacteric, women have the finitude of fertility and their productive capacity, which would represent the end of sexuality, among other issues.[2] Thus, the fragmented and reduced health actions for women in the climacteric remain, and they are more expanded and contextualized for women in the reproductive period.

Within this logic, the centralization of actions in the pregnancy-puerperal period has been the reserve of health resources for this area, keeping the strategies directed to women in the climacteric in the background. Thus, the Manual Comprehensive Care for Women's Health in the Climacteric/Menopause warns of the need for this group to be included in strategic, technical, and financial planning, with a focus on investing in health actions.[4] Women in this period are 15.5% of the Brazilian female population, approximately representing 16.21 million people,[5] justifying the need for actions that consider their specificities and needs.

Some chronic-degenerative diseases due to changes resulting from the climacteric are also important to highlight such as Systemic Arterial Hypertension (SAH), which occurs from the decrease in the hormone estrogen and it is responsible for protecting the woman's blood vessels.[6] Therefore, considering that gradual hypoestrogenism is an inherent characteristic of

climacteric, SAH is a chronic non-transmissible disease (CNCD), with higher levels in women from the fifth decade of life.[7] Furthermore, SAH consists of a public health problem directly implicated in the appearance of cardiovascular diseases, which are the main causes of mortality worldwide.[8]

Thus, in the case of women, hormonal, circulatory and blood changes due to the climacteric can potentiate cardiovascular risks, reinforcing the need for comprehensive care for this group, assessing early cardiovascular risk factors to reduce morbidity and mortality.[6] Thus, care for women in the climacteric appears as a demand in the health promotion and longitudinal care area in PHC.[9] In this perspective, the work of the nurse is fundamental since he is responsible for articulating, coordinating, and conducting care practices.[10]

However, these practices need to go beyond the execution of technical knowledge, and they must include welcoming, bonding, accountability, and resolvability. It is essential to articulate different practices of the organizational framework of SUS, regardless of the technological density used.[11]

Thus, this study aimed to answer the following research question: how do women in climacteric with SAH attached to the Family Health Strategy identify their care needs? The objective is to understand the care needs of women in climacteric with SAH.

Method

This is a qualitative study. Qualitative research enables the interpretation of phenomena, the description and analysis of reality,[12] and the experiences, symptoms, and needs of women in climacteric with SAH. The study scenario was all Family Health Units (FHU) in a municipality located in southern Brazil, totaling 21 services.

The selection of participants took place intentionally. They were identified from the database linked to the matrix project that involved the stratification of cardiovascular risk of users seen in the city's Primary Care, with the authorization of the responsible researcher. The

selection criteria used were: women between 40 and 69 years old due to the matrix project bank divided into age groups every ten years; with a referred diagnosis of SAH, attached to the FHUs and who reported not using hormonal contraceptives, totaling 42 women.

Of these, we interviewed 15 women since 16 of them did not accept to participate in the study, and nine were not located via phone and address. We made three telephone attempts and two trips to their homes. We opted not to be accompanied by the Community Health Agent to provide privacy to women. In one case, the husband answered for the wife, not allowing her participation, and one woman died. Data collection took place between April and June 2019. The initial contact with the participants was by telephone, inviting them to schedule the interview and define the place. The women chose to do them at home (14) or at the FHU (one), which was accepted by the researcher.

During the interview by a single interviewer, the term "menopause" was used instead of "climacteric", and the term "high blood pressure" instead of "SAH" to facilitate the understanding of the participants. During the interview, we clarified these concepts. The interviews had two stages: the first with data referring to the sociodemographic characterization of the participants and the second with questions that dealt with life after the onset of symptoms, care during the climacteric period, hypertension and who assisted in this process; doubts and who helped them understand them better; care needs; how the nurse could help; expectations in the FHU and the nurse; the opinion about a health group that addressed these topics, and the possible day and time to return to the interview. The average duration of each interview was 30 minutes, and they were recorded on a digital recorder, type MP3 Player®.

We used a participatory analysis, which follows the steps of transcribing the interviews; making the narratives, and returning the narratives to the participants.[13] After the transcription, we built individual narratives conducted as a story, and presented to the participants, according to the time and place of their preferences. When the narratives returned, the story was read aloud,

providing corrections or suppressions. In the return, we used a digital recorder of the type MP3 Player®, with an average duration of 45 minutes. Between the interview and the return of the narrative, there were at least two weeks to obtain greater authenticity in the answers.[13] We applied this process to all participants. Using the narrative transcripts, we organized the argument centers in a QSR NVivo 12 PRO® software, available in the free version.

The study respected the ethical precepts of Resolutions 466/2012 and 510/2016, of the National Health Council. The Research Ethics Committee approved the project on January 11, 2019, under Opinion 3,111,239 and CAAE 05333118.2.0000.5346. All participants signed the Informed Consent Term. To maintain their anonymity, the names of the women were replaced by the letter "N", which identifies the process of the narrative, and the numbers from 01 to 15, forming codes, for example, N-01.

Results

Fifteen women in climacteric and with SAH participated in the study, living in areas assigned to the FHUs. Of these, eight (53.3%) were between 50 and 59 years old, and there were four (26.6%) between 40 and 49 years old and three (20.0%) between 60 and 65 years old.

As for education, eight (53.3%) studied between zero and eight years, six (40.0%) between nine and 11 years, and one (6.6%) studied for 12 years or more. When dealing with the occupation, nine (60.0%) were salaried or self-employed, four (26.6%) were housewives, one (6.6%) was unemployed and one was a pensioner (6.6%). Seven (46.6%) were legally married, five (33.3%) were divorced, one (6.6%) was single, one (6.6%) was in a common-law marriage and another participant (6.6 %) was a widow.

When dealing with ethnicity, seven (46.6%) said they were white, five (33.3%) brown, while three (20.0%) were black. As for income, seven (46.6%) received between one and two minimum wages, four (26.6%) received two to three minimum wages, three (20.0%) received up to one

minimum wage and one (6.6%) received more than five minimum wages. When asked about religion, 12 (80.0%) said they were Catholic and three (20.0%) were Evangelical.

The understanding of the care needs of women in climacteric with SAH goes through the identification of signs and symptoms related to climacteric. Such manifestations were perceived with different intensities by women, based on their perceptions and experiences since some of them perceived the signs and symptoms more intensely, while the changes inherent to this period were not perceived by others.

> *I have these hot flashes, these horrible things. This menopause is horrible. I don't know either, but I went to the gynecologist once, and he said that those who have diabetes cannot undergo treatment for menopause, so I don't take anything [...]. And then my life changed a lot. (N-01)*

> *When menopause started, I had to remove the uterus, ovaries, and tubes, because I had fibroids inside and out. But those hot flashes, sweat, and high blood pressure continue. (N-02)*

> *I feel many hot flashes, very anxious. There are nights it takes me to fall asleep. I feel like I'm angry. It gives me that headache, and I turn everything off at home. I do my thing and go to bed and stay very still. I even fight with animals. (N-03)*

> *I never had the hot flashes. Only after 40, the pain starts here, pain there, but I think it is not from menopause, but not from having those hot flashes. (N-05)*

From these reports, we can identify that "going through menopause" has repercussions on different experiences for women, given that the signs and symptoms can vary the intensities. In this way, the care needs arising from the climacteric demand singular planning of the care provided, to be resolutive, continuous, and accessible to the woman.

In addition to the signs and symptoms presented in previous reports, women lived with bodily changes. They had weight gain for example.

> *My weight changed a lot [...] from 72 to 95. (N-02)*

> *I weighed 64-65, and now I weigh 70, and there's no way around it, I walk and dance, and there's no way [...]. (N-09)*

> *I see changes in the body, everything has changed, the organism is not the same. My weight has increased by about 10 kilos. (N-15)*

Mood changes are also common symptoms of menopause. However, while some participants reported significant mood swings, others did not notice them. This is due to the singularity of the period. Women perceive themselves in different ways as indicated by the reports.

> *My mood has changed, it gives me depression [...]. Sometimes I'm fine, and soon it will change. I became more forgetful, and the psychologist even said it was from stress. (N-03)*

> *My mood has not much changed. (N-11)*

> *My mood remained the same [...] it did not change. (N-04)*

Regarding their work, the participants reported tiredness and a change in the pace of carrying out work tasks. These changes made them quit from the labor market.

> *I notice that at work I changed my pace. I am much slower to get things done. And sometimes I am confused, I lose something, I forget things a lot. (N-03)*

> *I quit my job [...] because I got tired very easily [...]. (N-10)*

Understanding how women in climacteric live with SAH offers important clues about their care needs. Relevant aspects and with an impact on care planning included discomfort related to continuous treatment and difficulties in adhering to long-term medication therapy.

> *What has changed in my life is that I always have to take the medicine, that I have to take care of myself. (N-11)*

> *I am taking medicine. I take losartan, and I feel good because of the pressure normalizes. (N-04)*

> *There are days when it is at a high peak, and I take medicine daily, and there are times when I get tired of the medicines, I take so much. And then I stop [the medication] and it goes and comes again [...]. (N-08)*

> *I think it's ok [...] I don't make a point of taking medicine every day, then one day I went to the unit [USF] and they said it was pressure, then I take medication, 25 g hydrochlorothiazide, which is very weak [...]. (N-12)*

When dealing with food, women reported that, while not being able to eat properly, they sought to adjust meal times. Practices such as eating vegetables and decreasing the intake of foods rich in lipids have been reported; however, control over the use of sodium in meals is still a challenge.

> *I need to be more careful with the food [...] lowering the salt. (N-08)*

> *I have a lot of heartburn, so when I eat, I avoid eating fat [...]. (N-09)*

> *I eat very badly, I can't eat at noon, then I eat any snack and I go out, in the morning I can't have breakfast, only at night I eat better. (N-12)*

> *I eat rice, some beans, salad, vegetables because we eat my mother's food and we continue [...]. (N-13)*

As for the behavior adopted when presenting any doubt or insecurity during climacteric or SAH, women reported seeking information from different sources, such as doctors, family members, friends, and the Internet. Despite reports about this search process, some participants said they preferred not to know what was happening to their bodies.

> *I always ask the doctor a lot of questions, I like to be well informed. (N-02)*

> *I clarify on the Internet. I read a lot about diseases, everything [...] (N-08)*

> *If I am going to hear something that will make me confused and you are not willing to explain it, then I prefer to keep it there without my knowing that the person does not explain well and I still get hurt. (N-12)*

Due to the contribution that nurses can offer during the climacteric period and in the management of SAH, women were asked about the work of this professional at the FHU to which the participant was linked. The reports expressed the approach to this professional in circumstances such as the possibility of access to medical consultation, the performance of a cytopathological examination, the provision of guidance when performing the cytopathological examination, and the measurement of blood pressure levels.

> *I already consulted with the nurse [...] we first go with them and then the doctor arrives. (N-10)*

> *I don't look for the nurse to talk. But I always do my preventive exams with the nurse and she always guides me. (N-11)*

> *I never talked to the nurse about it, because I just went to the doctor, and then she said it was menopause, but I never had the nurse accompanying me. (N-13)*

> *What is missing there are more doctors. There is a doctor, but it is difficult to get an appointment. And now a gynecologist is missing, I don't know why there isn't one. I never talked to the nurse [...] the nurse has to clarify things for us. (N-14)*

> *The nurse helps [...] she checks people's pressure before and after exercise. She has that little piece of paper, so she goes straight. The nurse explained to me what menopause was. (N-09)*

From these results, we identified that women in climacteric and with SAH had care needs. Among the main signaled demands, there are aspects such as the management of the signs and symptoms from the climacteric (hot flushes, sweating, anxiety, mood changes, weight

gain, and fatigue); monitoring blood pressure levels, the effectiveness of drug therapy and adherence to the prescribed treatment; guidance on accessible and healthy food choices; the importance of searching for information from reliable sources; and the performance of active listening, reflecting in understandable guidelines by the woman, based on a horizontal relationship.

Discussion

Most of the participants in this study were between 50 and 59 years old. Most studied between zero and eight years, were employed or self-employed, legally married, white and received one to two minimum wages, which is consistent with a study in the city of Prudente, in the State of São Paulo, which identified that women in menopause were on average 51 years old, had incomplete primary education, were married, white and had an income of up to three minimum wages.[14]

The interviewees mentioned signs and symptoms such as hot flushes, increased sweating, headache, anxiety, irritability, and increased BP, relating them to the climacteric. It is a complex period in the woman's life, especially due to the biopsychosocial changes from this phase, whose symptoms negatively impact the daily activities of women, if they are not controlled.[15] Such symptoms may reflect on genital (reduced libido), extragenital (atrophy and dystrophy of the vulva, pain, dryness and vaginal bleeding), and psychic manifestations (hot flushes, sweat, headache, tiredness, weakness, irritability, mood swings, and depression), similar to the reports of the participants in this study.[16]

Participants reported weight gain and difficulties in eating a healthy diet, even doing it at planned times and making adequate nutritional and caloric intake. Inadequate eating habits have repercussions on bodily changes that have a major impact on altering body image, reflecting negatively on the perception of their body, sometimes interfering with the state of mental health.[17]

Changes in weight and mood changes and physical fatigue at work mentioned by the participants may be related to changes in women's living conditions. Such changes have been significant in recent decades, such as the increase in the entry of women into the labor market and the inversion of social roles,[18] which can result in overload for them, generating physical fatigue and mental exhaustion. Considering that these women are between 50 and 65 years old, fatigue can also be related to increasing age, concomitant with physiological and hormonal changes. In this sense, it is clear that this symptom can be aggravated according to work activities, food, and sleep regulation.

The participants reported that stress, anxiety, discouragement, memory loss, lack of concentration, and sudden mood changes are events and sensations inherent to this phase. The change in mood is a symptom that can occur during the physiological process of the climacteric because, during this period, there is a decrease in the hormone estrogen, which significantly raises the prevalence of depression, emotional reactivity, and cognitive changes that can be related to a higher prevalence of irritability, stress, sadness, and depression.[19]

We also identified that women in climacteric with SAH had difficulties adherence to long-term SAH drug therapy, and did not understand its importance. These difficulties may be due to possible fears regarding the use of medication and the chronicity of the disease, which may result in an increased risk for the development of cardiovascular events, such as acute myocardial infarction and stroke, for example. Thus, treatment adherence is another need for care to be addressed by nurses.

Thus, the literature states that low education, age, and irregularity in attending gynecological consultations contribute to a lack of understanding of the climacteric, its signs and symptoms, and its management/treatment.[20] Study that analyzed the profile of women with SAH shows that the lowest wage income can be pointed out as a problem in the process of

treatment adherence and, consequently, in the control of blood pressure levels,[8] corroborating the findings of this study.

The difficulty of adhering to drug treatment results in decompensated blood pressure, increasing the risk of cardiovascular events.[8] In this sense, the care to be offered to these populations must encompass health education, a practice that needs the nurse to identify the woman's potential and difficulties in understanding her diagnosis. Consequently, the nurses should take care of their clinical condition, providing guidance on the medications to be used, their benefits and side effects, and the possible impacts of lack of adherence to the presented pathology.

From the analysis of the reports of women in climacteric with SAH, we identified the management of signs and symptoms resulting from the climacteric as care needs, including weight gain, change in mood, change in the rhythm of work due to physical tiredness, and monitoring the blood pressure level, the effectiveness of drug therapy and adherence to the prescribed treatment. We also identified the need for guidance on accessible and healthy food choices, the importance of seeking information from reliable sources, the performance of active listening, and comprehensible and accessible guidelines for this population.

When dealing with the health care of women in climacteric with SAH, we need to reflect on the work of the nurses, and improve practices and develop care aligned with the specific context experienced by these women. These care needs are guided by social, historical, economic, and cultural aspects, and the needs and specificities of women, given the unique experience in this stage of life.[21]

Therefore, the nurse must develop health promotion and education actions aimed at disease prevention, providing FHU users with collective spaces for the exchange of knowledge, to answer questions regarding healthy and accessible food, both for their nutritional needs, regarding socioeconomic conditions.[16] Also, guidance on regular physical activity can be given since such practice has a positive effect on blood vessel walls and has vasodilating action,

contributing to healthy aging and preventing the manifestation of comorbidities such as SAH in the climacteric period.[18]

This study allowed us to identify that the common and physiological symptoms of menopause are not always experienced by all women. Several factors are related to perceptions about symptoms, such as socioeconomic conditions, ethnicity, marital status, and the quality of family relationships.[22] Therefore, the care needs to be individualized and adapted to the experiences and conditions of each woman. Tit is very important that nurses have deep knowledge about the characteristics of the population assigned to the FHU, so that the care offered is planned based on the needs of each woman and that it is possible to promote comprehensive and equitable care.

The perception of the nurse's work led to the way of care developed by this professional, predominantly aligned with the individual perspective of care. In this sense, we noticed that the women identified them from the reception for a subsequent referral to medical consultation. They also mentioned that this professional developed the consultations to perform a cytopathological exam and provide guidance related to the exam and its health condition, monitoring blood pressure levels. These indications show that the nurse's work is related to clinical practice and individual education actions, such as guidelines.

Based on the identified perceptions, the nurses need to broaden their area of vision to materialize care, both individual and collective, including women living in the area assigned to the FHU. They must create bonds and understand the care needs of each patient, promoting actions based on the achievement of comprehensible and accessible guidelines. The nurse needs to create a service space for women in the climacteric to provide an opportunity for qualified listening to the feelings and desires inherent to this phase of their life. The professional can offer guidance, information on changes, and emotional support to minimize the discomfort resulting from unpleasant changes and possible negative health implications. They can also contribute to

deconstructing myths and prejudices, encouraging reflections that deconstruct stereotypes that limit the full experience of women in climacteric with SAH, including their sexuality.[23]

When carrying out the nursing consultation with women close to the climacteric, the nurse needs to bring information related to NCTDs (for example SAH, Diabetes Mellitus, and chronic pain). With this, they can guide the possible signs and symptoms resulting from these pathologies, discussing the climacteric, and making these women experience this process more calmly.[24-25]

In this way, we intend to collaborate with the nurse's practice in caring for women in climacteric with SAH, showing the need for planning and implementing comprehensive care practices. From this perspective, we can know the woman in her entirety, understanding her as someone who is the result of her different experiences, and helping nurses to develop care based on their professional praxis.

The limitations of the study include the possible interference from the participation of one or more family members of the women at the time of the interview. Some women chose to answer the interview and return their narrative in their workplace, which may have influenced the time available and the quality of the answers provided. There is also a limit in the discussion of the results since no studies have been identified that deal with the climacteric and SAH comprehensively. Finally, we suggest the development of new studies to deepen the understanding of this specific phase of the woman's life, expanding the perspective that women's care should be restricted to the fertile and puerperal period.

Conclusion

This study shows that the experience related to climacteric occurs differently among women and that the presence of SAH in this phase of life is a challenging reality for the women and for the nurses who work at the FHUs. The participants little knew about the climacteric and some knowledge about SAH and its repercussions, showing the need to adapt to eating

habits and manage stress. However, adherence to drug therapy remained a complex condition, referring to the need for nurses to expand their practices for health promotion, disease prevention, and health education actions.

When dealing with the nurse's work, the women identified that these professionals performed care individually and punctually, requiring an expansion of their care. This finding can be one of the contributions of this study, considering that it can be a subsidy for nurses in the implementation of strategies that allow the prevention of diseases and the promotion of the health of women in the climacteric with hypertension, and the reduction of morbidity and mortality from NCTDs. Thus, we suggest the incorporation of practices such as home visits, groups, among others, that start from the perspective of horizontal relationships and provide opportunities for the exchange of experiences and knowledge between women and professionals.

References

1. Instituto Brasileiro de Geografia (IBGE). Pesquisa nacional por amostra de domicílios contínua 2018 [Internet]. Brasília (DF): IBGE; 2018 [acesso em 2020 jan 10]. Disponível em: https://educa.ibge.gov.br/jovens/conheca-o-brasil/populacao/18320-quantidade-de-homens-e mulheres.html

2. Ministério da Saúde (BR). Política Nacional de Atenção Integral à Saúde da Mulher: princípios e diretrizes. Brasília (DF): Ministério da Saúde; 2004.

3. Silva VH, Rocha JSB, Caldeira AP. Fatores associados à autopercepção negativa de saúde em mulheres climatéricas. Ciênc Saúde Colet. 2018;23(5):1611-20. doi: 10.1590/1413-81232018235.17112016.

4. Ministério da Saúde (BR). Manual de atenção à mulher no climatério/menopausa. Brasília (DF): Ministério da Saúde; 2008.

5. Instituto Brasileiro de Geografia e Estatística (IBGE). Contagem da População 2015 [Internet]. Brasília (DF): IBGE; 2015 [acesso em 2020 jan 15]. Disponível em: http://www.ibge.gov.br/home/estatitica/população/domcavati/defaut.shtm

6. Melo JB, Campos RCA, Carvalho PC, Meireles MF, Andrade MVG, Rocha TPO, et al. Fatores de risco cardiovasculares em mulheres climatéricas com doença arterial coronariana. Int J Cardiovasc Sci.

2018;31(1):4-11. doi: 10.5935/2359-4802.20170056

7. Sociedade Brasileira de Cardiologia; Sociedade Brasileira de Hipertensão; Sociedade Brasileira de Nefrologia. VI Diretrizes brasileiras de hipertensão. Arq Bras Cardiol. 2010;95(1 Suppl 1):1-51. doi 10.1590/S0066-782X2010001700001

8. Silva SSBE, Oliveira SFSB, Pierin AMG. The control of hypertension in men and women: a comparative analysis. Rev Esc Enferm USP. 2016;50(1):50-8. doi: 10.1590/S0080-623420160000100007

9. Oliveira ZM, Vargens OMC, Santos RS. Cuidado de enfermagem no climatério: perspectiva desmedicalizadora na atenção primária de saúde. Rev Enferm UFPE On Line [Internet]. 2017 [cited 2020 Jun 10];11(Suppl 2):1032-43. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/13474

10. Treviso P, Peres SC, Silva AD, Santos AA. Competências do enfermeiro na gestão do cuidado. RAS Rev Adm Saúde. 2017;17(69). doi: 10.23973/ras.69.59

11. Sousa SM, Bernardino E, Crozeta K, Peres AM, Lacerda MR. Cuidado integral: desafio na atuação do enfermeiro. Rev Bras Enferm. 2017;70(3):504-10. doi: 10.1590/0034-7167-2016-0380

12. Minayo MCS. O desafio do conhecimento. São Paulo: Hucitec; 2014.

13. Campos RTO, Furtado JP. Narrativas: utilização na pesquisa qualitativa em saúde. Rev Saúde Pública. 2008;42(6):1090-6. doi: 10.1590/S0034-89102008005000052

14. Peixoto LN, Araujo MFS, Egydio CA, Ribeiro FE, Fregonesi CEPT, Carmo EM. Perfil e intensidade de sintomas de mulheres no climatério avaliadas em unidades básicas em saúde em Presidente Prudente. Colloq Vitae. 2015;7(1):85-93. doi: 10.5747/cv.2015.v07.n1.v129

15. Cardoso MR, Camargo MJG. Percepções sobre as mudanças nas atividades cotidianas e nos papéis ocupacionais de mulheres no climatério. Cad Ter Ocup UFSCar. 2015;23(3):553-69. doi: 10.4322/0104-4931.ctoAO0574

16. Fonseca EJNC, Figueiredo Neto JA, Rocha TPO, Nogueira IAL, Melo JB, Melo JB, et al. Síndrome metabólica e resistência insulínica pelo Homa-IR no climatério. Int J Cardiovasc Sci. 2018;31(3):201-8. doi: 10.5935/2359-4802.20180009

17. Caluête MEE, Nóbrega AJS, Gouveia RA, Galvão FRO, Vaz LMM. Influência do estado nutricional na percepção da imagem corporal e autoestima de idosas. Rev Bras Geriatr Gerontol. 2015;18(2):319-26. doi: 10.1590/1809-9823.2015.14062

18. Schmidt PJ, Dor RB, Martinez PE, Guerrieri GM, Harsh VL, Thompson K, et al. Effects of estradiol withdrawal on mood in women with past perimenopausal depression: a randomized clinical trial. JAMA Psychiatry 2015;72:(7):714-26. doi:10.1001/jamapsychiatry.2015.0111

19. Pereira MC, Cárdenas MH. Visión filosófica del cuidado humano en la mujer en la etapa del climaterio. Enferm Cuid Humaniz. 2019;8(1):34-45. doi: 10.22235/ech.v8i1.1795

20. Lomônaco C, Tomaz RAF, Ramos MTO. O impacto da menopausa nas relações e nos papéis sociais estabelecidos na família e no trabalho. Reprod Clim. 2015;30(2):58-66. doi: 10.1016/j.recli.2015.08.001

21. Piecha VH, Ebling SBD, Pieszak GM, Silva MM, Silva SO. Percepções de mulheres acerca do climatério. Rev Pesq Cuid Fundam. 2018;10(4):906-12. doi: 10.9789/2175-5361.2018.v10i4.906-912

22. Ferreira ICC, Silva SS, Almeida RS. Menopausa, sinais e sintomas e seus aspectos psicológicos em mulheres sem uso de reposição hormonal. Ens Ciênc [Internet]. 2015 [acesso em 2020 jan 26];19(2):60-4. Disponível em: https://revista.pgsskroton.com/index.php/ensaioeciencia/article/view/3182/0

23. Santos SMP, Gonçalves RL, Azevedo EB, Pinheiro AKD, Barbosa CA, Costa KNF. A vivência da sexualidade por mulheres no climatério. Rev Enferm UFSM. 2014;4(1):113-22. doi: 10.5902/217976928819

24. Curta JC, Weissheimer AM. Percepções e sentimentos sobre as alterações corporais de mulheres climatéricas. Rev Gaúcha Enferm. 2020;41(Spec No):e20190198. doi: https://doi.org/10.1590/1983-1447.2020.20190198

25. Santos TT, Barilli SLS, Porciuncula MB, Almeida RSC, Specht AM. Avaliação do risco cardiovascular em mulheres docentes no fim do período reprodutivo. Rev Enferm UFSM [Internet]. 2020 [acesso em 2020 jul 30];10(e38):1-16. Disponível em: https://periodicos.ufsm.br/reufsm/article/view/38513/html

Chief Scientific Editor: Cristiane Cardoso de Paula
Associated Editor: Tassiane Ferreira Langendorf

Funding/Acknowledgment: Universidade Federal de Santa Maria.

Corresponding author
Lara Castilhos
E-mail: laracastilhos23@gmail.com
Endereço: Rua Inácio Domingos Velho, 49 – Centro. Santa Rosa do Sul/SC.
CEP: 88.965-000

Authorship contributions

1 – Lara Castilhos

Conception or design of the study/research, analysis, and/or interpretation of the data, final review with critical and intellectual participation in the paper.

2 – Maria Denise Schimith
Conception or design of the study/research, analysis, and/or interpretation of the data, final review with critical and intellectual participation in the paper.

3 – Laís Mara Caetano da Silva
Analysis and/or interpretation of data, final review with critical and intellectual participation in the paper.

4 – Lisie Alende Prates
Analysis and/or interpretation of data, final review with critical and intellectual participation in the paper.

5 – Nara Marilene Oliveira Girardon-Perlini
Analysis and/or interpretation of data, final review with critical and intellectual participation in the paper.

How to cite this article

Castilhos L, Schimith MD, Silva LMC, Prates LA, Girardon-Perlini NMO. Care needs of women in menopause with hypertension: nurses' work possibilities. Rev. Enferm. UFSM. 2021 [Access on: Year Month Day]; vol.11 e15: 1-19. DOI:https://doi.org/10.5902/2179769242948