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HEALTH PROMOTION FOR WOMEN IN THE CLIMACTERIC PERIOD IN PRIMARY CARE

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Abstract: The climacteric is the transition period between a woman's fertile and infertile periods. During this phase, due to hormonal changes, there are various physical, mental and social factors that affect the quality of life of this population. Within primary care, there are protocols and manuals drawn up by the Ministry of Health, with the aim of offering support to these women. The overall aim of this research is to identify difficulties in women's lives caused by the climacteric. In order to carry out this proposal, an exploratory, longitudinal, descriptive field study with a qualitative approach was carried out with 30 women between the ages of 40 and 55, implemented at the Center for Integral Attention to Women's Health (CAIS MULHER). Among the results presented, it was observed that there is a lack of literacy in women's health beyond the menopause, such as the presentation of physiological symptoms, discussion of hormonal therapies and non-pharmacological treatments, as well as teaching about quality of life and sexuality. It was also shown that symptoms and lifestyle are related to quality of life during this phase. The conclusion is that welcoming and actively listening to women in the climacteric age group, as well as using and updating the manuals and protocols that already exist within the basic units, will help to spread self-knowledge and the search for a dignified life for women during this period. This research can thus serve as an aid for planning and maintaining scientific material and improving care for this population.
Keywords: Women's Health; Climacteric; Health Promotion.

INTRODUCTION

The climacteric is the phase that precedes the menopause. It is the period of change between a woman's fertile and non-reproductive phases. It occurs between the ages of 40 and 65 and it is at this time that the main com-

plaints can begin. The menopause is established 12 consecutive months after the last menstrual period and represents the real end of the reproductive period. The climacteric is a natural phase of life for all women, it is not a pathology, it is a process of transformation (BRASIL, 2008).

In Brazil, according to the IBGE, women's life expectancy in 2023 will be approximately 80.86 years. This shows that after the climacteric period, women will still live through their senescence for approximately another 30 years, and this transition period corresponds to only 1/3 of their lives. Therefore, women should experience this phase with all their fullness and well-being (FREITAS *et al.*, 2004).

The climacteric period corresponds to the following phases: pre-menopause, perimenopause and post-menopause. Pre-menopause occurs when menstruation starts to become irregular, with more than 3 months of amenorrhea. Perimenopause, on the other hand, is the period that has not yet reached 12 months with no menstruation. Finally, the post-menopause is when this cycle finally ends, 2 years after the start of the menopause, and lasts until the end of the woman's life (SANTOS, 2007).

At this stage of the female population's life, due to the various changes in hormone production and ovarian functionality, the appearance of some symptoms is notable. Symptoms can be transient or non-transient. Among the main clinical manifestations are: hot flushes, sweating, chills, insomnia, headaches, dizziness, paresthesia, memory loss, irritability, anxiety, depression, low self-esteem, among other vasomotor or neuropsychic symptoms (BRASIL, 2008).

In 2004, the Ministry of Health instituted the National Policy for Comprehensive Women's Health Care (PNAISM). This document aimed to promote comprehensive health care for women. Among the specific objectives of this policy is the need to insert and implement protocols when caring for climacteric women. This will be guaranteed by using the Manuals of Care for Women in the Climacteric and Menopause in addition to the basic care protocols (BRASIL, 2004).

The Climacteric Women's Care Manual is a tool created by the Ministry of Health's Women's Health Technical Area that helps professionals to deal with the care of climacteric women, highlighting guidelines, rationale and biopsychosocial aspects that should be addressed, as well as dealing with conditions associated with menopause such as osteoporosis and cancers, preventive measures and available therapeutic options. The manual also addresses issues related to the sexuality of these women, in other words, it aims to take a holistic approach to caring for women (BRASIL, 2008).

As already mentioned, the climacteric and menopause are not a disease. Thus, the World Health Organization (WHO) reports that health during this period depends on various factors, including the availability of health services. Thus, in addition to care services, trained professionals are needed, and nursing has a notable role to play during this phase of a woman's life, given that nursing consultations within the family health strategy are the exclusive responsibility of nurses, according to Law No. 7,498/1986 (BRASIL, 1990).

For a long time, women's health was focused on pregnancy. However, feminist movements and the modernization of society have changed this scenario. Despite this, there is still a lack of approaches that take into account all stages of women's lives. Bringing this exercise to the climacteric, there are protocols and manuals to facilitate the implementation of efficient and effective health actions, changing the course of this population's quality of life. This material questions the perceptions and obstacles of climacteric women and how the health promotion actions stipulated in the manuals take place (BRASIL, 2008).

According to data from the Brazilian Institute of Geography (IGBE) in 2014, there are around 29 million women in Brazil in the climacteric and menopause phase, i.e. 27.9% of the female population is experiencing this process of major changes in physical, social and psychological health. With this in mind, we investigated what these patients' main complaints might be, in addition to the basic symptoms, and what aspects should be explored in gynecological consultations within Primary Health Care (PHC) (CANDIDO, 2019).

This study contributed to the implementation and strengthening of conducts in the work of health professionals during the climacteric period. It is noteworthy that the results contributed to understanding women and their dilemmas in relation to the proposed theme, favoring a care practice appropriate to the needs of women in the climacteric phase.

The biggest challenge of this study was to observe and verify the implementation of health promotion practices, the protocols aimed at climacteric women and how the reception and nursing consultation takes place within the Family Health Strategy (ESF). In addition, what the main symptoms of these women are, what guidance is needed to help perpetuate this phase in their lives and how the ESF can support and refer these patients to the necessary care, making the care comprehensive.

Therefore, considering the importance of guidance and health literacy in the climacteric phase, taking into account all the demands generated by this growing population, in addition to the existing actions and knowledge, the question was asked: What is the knowledge and difficulties faced by women in the climacteric period?

OBJECTIVES

GENERAL OBJECTIVE

To identify difficulties in women's lives caused by the climacteric.

SPECIFIC OBJECTIVES

- To identify the interfaces of gynecological consultation with climacteric women.
- To describe the importance of health promotion practices in accordance with existing policies.

THEORETICAL FRAMEWORK

CLIMACTERIC: ANOTHER PHASE IN A WOMAN'S LIFE

The climacteric refers to the period of transition from the reproductive phase to the non-reproductive phase, characterized by a decrease in ovarian function. Menopause corresponds to the definitive cessation of menstruation after 12 consecutive months of amenorrhea (BLÜMEL et al., 2014). This phase involves various physiological and psychosocial changes, which should not be seen as a disease, but as part of the natural aging process (BRASIL, 2008).

Physiological symptoms include cardiovascular, metabolic, musculoskeletal and urogenital changes (BLÜMEL et al., 2014). Emotional symptoms include anxiety, depression, insomnia, irritability and cognitive changes, often aggravated by the socioeconomic context and social stigmas (BRASIL, 2016; PATRÍCIO et al., 2020).

The fall in oestrogen affects sexual health, causing vaginal dryness, dyspareunia, reduced libido, uterine prolapse and a higher risk of STIs. Self-care and self-knowledge are essential for maintaining health and quality of life (AMARAL, 2020). Contraception is still relevant at this stage, as fertility may be present, and pregnancy may pose risks (DI BELLA et al., 2016).

Factors such as smoking, alcohol consumption, chronic diseases and medication use influence the severity of symptoms. Nurses play an important role in preventing osteoporosis through tests such as bone densitometry and laboratory tests (BACCARO et al., 2022).

Screening for cancers (cervix, breast, ovarian, skin, colon and rectum) is essential during consultations. The nurse carries out preventive tests, monitors problems and can recommend treatments (BRASIL, 2008). In addition to hormone therapy, alternatives are recommended such as herbal medicines, acupuncture, meditation and lubricants, which relieve symptoms and improve well-being (GARCÍA, 2019).

Health promotion should include diet, physical activity, psychological support, cognitive strengthening and a support network. Multidisciplinary work and a humanized approach are fundamental to therapeutic success (PATRÍCIO et al., 2020). Thus, it is up to PHC to provide comprehensive, resolutive and welcoming care, based on ethics and respect for individuality (BRASIL, 2008).

HUMANIZATION AND ETHICS IN CLIMACTERIC WOMEN'S HEALTHCARE

Climacteric care must be based on bioethics, which guides professional practice by the principles of autonomy, beneficence, non-maleficence and justice (BRASIL, 2008). Autonomy involves valuing women's choices and paying special attention to vulnerable groups. Strengthening citizenship and access to information are essential (BRASIL, 2008).

The National Health Promotion Policy (2006) values women's autonomy and protagonism, especially in the face of the limitations imposed by the social view of the climacteric. The ESF should promote empowerment and offer therapeutic alternatives suited to each woman's reality (DURAND, 2013).

Beneficence and non-maleficence require up-to-date, ethical and responsible conduct, ensuring safe and respectful care (BARBOSA, 2017). Justice ensures equitable treatment, based on the principles of the SUS: universality, equity and comprehensiveness (BARBOSA, 2017).

Since 2003, the National Humanization Policy (NHP) has proposed person-centred care, recognizing the patient as a subject of rights (BRASIL, 2013). In the climacteric, this means active listening, empathetic consultation and welcoming complaints with respect for the physical, mental and social dimensions (BRASIL, 2008).

It is important to discuss ethical dilemmas, such as the use of hormone replacement - often seen as a cure for ageing - and hysterectomy as a standard solution for bleeding. Such conduct can go against bioethical principles if applied indiscriminately (BRASIL, 2008).

Nurses should use clear language, respect the patient's time and context, adopt non-violent communication and strengthen autonomy. Ethics and humanization are indispensable for comprehensive care (BARBOSA, 2017).

HUMANIZED CARE FOR WOMEN

PAISM (1984) was a milestone in comprehensive care for women's health, proposing a more sensitive and holistic model. Despite this, obstacles persist, such as the low quality of care and lack of effective reception (BARBOSA, 2006).

Humanized care requires team coordination, problem-solving and multidisciplinary work. The PNH guides care in PHC, promoting welcoming and bonding from the first contact (SIMÕES et al., 2007).

The approach must go beyond the biomedical model and consider women as a whole. The humanized consultation strengthens the bond, allows for qualified listening and favors the resolution of demands (BRASIL, 2008).

The humanistic model replaces invasive practices with care technologies, promoting safety and respect (FERNANDES, 2013). Comprehensive care must follow the principles of Law 8.080/90, focusing on health promotion, protection and recovery (SECRETÁRIA DE ESTADO DE SAÚDE, 2023).

The ethical and humanistic training of professionals must be permanent. Permanent Health Education (EPS) updates practices and improves the quality of care for women (BRASIL, 2018). Dialogue during the consultation strengthens the patient's autonomy and the bond with the team (CARNEIRO, 2012).

The humanized gynecological consultation provides comfort, security and protagonism to the woman over her body and health (FERNANDES, 2013). The PNAB reinforces care based on equity, bonding and accessibility, with a strategic focus on women's health (BRASIL, 2006).

NURSING PRACTICE IN THE CLIMACTERIC

Nursing consultations during the climacteric should address women's physical, emotional and social aspects. Despite this, there is still a lack of professional preparation in relation to the specificities of this phase (DIÓGENES, 2010).

Nurses need to develop qualified listening, welcoming and empathetic communication. These elements favor the creation of bonds and effective interventions (DIÓGENES, 2010). The SNC and the NP organize care and promote the individualization of care (GARCÍA, 2019).

Law 7.498/86 guarantees the autonomy of nurses in carrying out consultations, collecting data and drawing up therapeutic plans. The aim is to promote autonomy and health education (GARCÍA, 2019).

Tools such as lectures and campaigns help to reach the target population. Protocols and manuals should be used as a basis for ongoing education (GARCÍA, 2019).

Common diagnoses include "Anxiety", "Insomnia", "Ineffective thermoregulation", among others (HERDMAN et al., 2018). Non-pharmacological interventions, such as meditation, yoga, acupuncture and Kegel exercises, are also indicated (BRASIL, 2008).

Nurses can order tests such as FSH, TSH, Estradiol, glycemia, cholesterol and mammography, provided they are justified. In the event of alterations, referral to the doctor is necessary, respecting the periodicity of the tests (GARCÍA, 2019).

PROGRAM FOR CLIMACTERIC WOMEN IN PRIMARY CARE

The Manual for Comprehensive Care for Women's Health in the Climacteric/Menopause guides professional practice and unifies Ministry of Health guidelines (BRASIL, 2008). The Primary Care Protocol also offers practical guidelines for care (BRASIL, 2016).

Nurses play a leading role in implementing these documents, being responsible for listening, welcoming and making referrals (FERREIRA, 2017). According to the IBGE (2019), 74.5% of women over 45 have already gone through the menopause, highlighting the need for expanded care.

Even with existing guidelines, studies point to negligence in the care of climacteric women by PHC, due to the difficulty in identifying symptoms and the withdrawal of patients from services (LUZ et al., 2021).

Women's health is still mostly associated with motherhood, limiting the recognition of climacteric demands. It is necessary to break with the biomedical model and integrate care at all levels of care (LUZ et al., 2021).

The provision of appropriate clinics, psychological support, medication, therapies and social participation are fundamental to implementing the climacteric care guidelines (BRASIL, 2008).

METHODOLOGY

This is an exploratory, descriptive, cross-sectional field study with a qualitative approach, which began in November 2023. Descriptive research aims to present the reality of the object studied, while the qualitative approach is

exploratory and seeks to understand the social experiences of the participants, categorizing experiences based on subjective data analyzed with scientific rigor (MINAYO, 2004).

The research was carried out at the Center for Comprehensive Women's Health Care (CAIS Mulher), located in Anápolis, Goiás. The unit is a reference in women's health care, with an average attendance of 200 women per day, offering specialties such as gynecology, obstetrics, mastology, psychology, social assistance and various exams such as ultrasounds, mammograms, as well as services such as family planning, cancer prevention and making the SUS card (SECRETARIA MUNICIPAL DE SAÚDE, 2023).

The sample was made up of 30 cisgender women, aged between 40 and 55, climacteric and not pregnant at the time of collection. Women outside this age group or who had undergone oophorectomy before the age of 40 were excluded.

Data collection took place by appointment during the day. The participants were approached individually and given explanations about the study and the Informed Consent Form (ICF). After reading and clarifying any doubts, those who agreed to take part signed the ICF in two copies (APPENDIX A). The data was collected through semi-structured interviews (APPENDIX B).

The interviews took place preferably immediately after the signing of the informed consent form, in a private room, and could last up to two hours. The information was recorded using an MP3 recorder, with the participant's authorization. In the event of refusal, manual recording was used. After the interview, the women filled in a form with socio-cultural data.

The study was approved by the Research Ethics Committee of the Evangelical University of Goiás (opinion no. 6.454.140), following the guidelines of Resolution no. 466/2012 of the National Health Council, which regulates research with human beings (BRASIL, 2012).

All the interviews were carried out individually, with a guarantee of privacy, confidentiality, anonymity and freedom to withdraw at any time, without prejudice. The data remained under the responsibility of the researchers until the research was published and will then be stored for five years and incinerated.

The risk to the participant was considered minimal, although it was recognized that the content of the interviews could cause emotional discomfort, such as crying or embarrassment. Should this occur, support was offered and the possibility of interrupting or rescheduling the interview, without any penalty. If necessary, assistance was provided immediately, free of charge and in full.

As benefits, the participants gained knowledge about the climacteric, its manifestations and therapeutic possibilities. Contact with the PHC team promoted autonomy and self-knowledge about the body and self-care.

There were no costs for the participants. If there were, they would be reimbursed. They were also guaranteed compensation in the event of damage caused by their participation in the study, with free and full assistance.

The interviews were transcribed in full to ensure the accuracy of the information. The analysis was carried out according to Bardin (2016), following the stages of content analysis: pre-analysis, exploration of the material, treatment of the results, inference and interpretation.

DATA RESULTS AND DISCUSSIONS

A total of 30 participants took part in the study, whose socioeconomic and cultural information is shown in Table 1.

The prevalent age among the participants was 41 years (n=4, 13.33%), followed by an equal minority for all the following age groups:

55, 54, 53, 47, 45 years (n=1, 3.33%). With regard to marital status, the majority were married (n=12, 40%), accompanied by two equal minorities: widows and divorced women (n= 4, 13.33%). As for skin color, most of the participants said they were brown (n=19, 63.33%), followed by a second majority who said they were white (n=8, 26.66%) and a minority who said they were black (n=3, 10%).

As for their place of residence, they all lived in Anápolis - GO (n=30, 100%). With regard to the means of transportation used, the majority used private transport (n=15, 50%), followed by public transport (n=11, 36.66%) and a minority (n=4, 13.33%) used other means.

The majority of these women have three or more children (n=18, 60%), while the minority have no children (n=1, 3.33%). As for level of education, the majority had incomplete primary education (n=11, 36.66%), accompanied by two equal minorities who had incomplete secondary education and incomplete higher education (n=1, 3.33%).

With regard to how many people contribute to the family income, the majority have two contributors (n=17, 56.66%) and the minority have three or more contributors (n=3, 10%). With regard to current work, the majority work in commerce (n=12, 40%) and the minority who agree are retired or unemployed or are government employees or others (n=1, 3.33%). For those who are currently working, their income varies from one minimum wage (n=13, 43.33%) to five minimum wages (n=6, 20%), and there are participants who have no personal income (n=2, 6.66%).

AGE		**%**
55 years old	1	3,33%
54 years old	1	3,33%
53 years old	1	3,33%
52 years old	2	6,66%
51 years old	2	6,66%
50 years old	3	10%
49 years old	2	6,66%
48 years old	2	6,66%
47 years old	1	3,33%
46 years old	3	10%
45 years old	1	3,33%
44 years old	2	6,66%
43 years old	2	6,66%
42 years old	0	0%
41 years old	4	13,33%
40 years old	3	10%
CIVIL STATUS		**%**
Single	10	33,33%
Married	12	40%
Stable union	0	0%
Divorced	4	13,33%
Separated	0	0%
Widowed	4	13,33%
MUNICIPALITY OF RESIDENCE		**%**
Anápolis	30	100%
MEANS OF TRANSPORT		**%**
Private	15	50%
Public	11	36,66%
Other	4	13,33%
PSKIN COLOR		**%**
White	8	26,66%
Brown	19	63,33%
Black	3	10%
Red-Indian	0	0%
NUMBER OF CHILDREN		**%**
None	1	3,33%
One	2	6,66%
Two	9	30%
Three or more	18	60%
LEVEL OF EDUCATION		**%**
Incomplete primary education	11	36,66%
Complete elementary school	0	0%
Secondary school incomplete	1	3,33%
High school complete	10	33,33%
Incomplete higher education	1	3,33%
Complete higher education	7	23,33%
PSKIN COLOR		**%**
White	8	26,66%
Brown	19	63,33%
Black	3	10%
Red-Indian	0	0%

NUMBER OF CHILDREN		%
None	1	3,33%
One	2	6,66%
Two	9	30%
Three or more	18	60%
LEVEL OF EDUCATION		**%**
Incomplete primary education	11	36,66%
Complete elementary school	0	0%
Secondary school incomplete	1	3,33%
High school complete	10	33,33%
Incomplete higher education	1	3,33%
Complete higher education	7	23,33%
NUMBER OF PEOPLE CONTRIBUTING TO FAMILY INCOME		**%**
One	10	33,33%
Two	17	56,66%
Three or more	3	10%
CURRENT JOB		**%**
Informal	6	20%
Unemployed	1	3,33%
Retired	1	3,33%
Home	3	10%
Self-employed	3	10%
Trade	12	40%
Civil servant	1	3,33%
Liberal professional	2	6,66%
Other	1	3,33%
INCOME		**%**
Up to 1 minimum wage	13	43,33%
Up to 2 minimum wages	9	30%
Up to 5 minimum wage	6	20%
Up to 10 minimum wage	0	0%
No income	2	6,66%

Table 1 - Socio-economic and cultural aspects of the participants, Anápolis, 2024.

SOURCE: Own elaboration, (2024).

The following categories of analysis were listed to highlight the results found in the research: Knowledge about the climacteric; Influence of symptoms on quality of life; The relationship between social determinants, which will be discussed in the following topics.

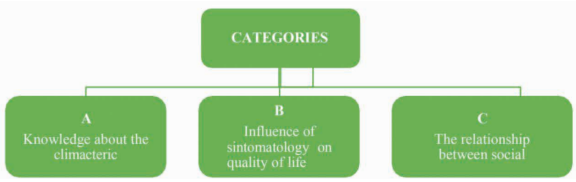

Figure 1 - Representative arrangement of the thematic categories that emerged from the interviews with the participants.

SOURCE: Own elaboration, (2024).

CATEGORY A - KNOWLEDGE ABOUT THE CLIMACTERIC

By analyzing the responses obtained during the interviews, this category aims to highlight the women's knowledge and difficulties during the climacteric period.

The data collected showed that most of the participants had no knowledge of the climacteric. In addition, there were women who claimed to have full knowledge of this issue, but through the conversations it was possible to see that their knowledge was shallow or completely mistaken, for example when they asked, "is it the menopause, the climacteric?" or during the answer they said that they had only heard about it through the media "what I've seen is about the media, that you read something, right", or even answered directly "no".

"[...] I work in a hospital, right, so I've heard that word there, but I don't remember what it is [...]" (Lily 11)

"[...] So, we know that the gynecologist doesn't explain anything, right? Very quick appointments. But we know that it's unbearable heat, it's something that just gets worse and worse, and this menopause comes when? [...]" (Agave 24)

"[...] So, as I'm a health worker myself, I know what it's like [...]" (Dracena 8)

"[...] No, it's the first time I've heard it. [...]" (Hibisco 25)

According to the Manual of Care for Women in the Climacteric and Menopause, health promotion in this period mainly involves these women knowing what this phase is all about. During consultations, health professionals should provide this knowledge and be available to answer questions. It is important to realize that each woman has her own challenges and should be assessed in a comprehensive and unique way (BRASIL, 2008).

Menopause and climacteric are associated as synonyms by the majority of the population. The lack of knowledge about this period has an impact on the quality of life of many women. Their family members and partners also lack knowledge about this stage, which makes the patient face this moment with many more difficulties, impacting not only on her physical, but also on her mental and social health (ALCANTARA *et al.*, 2020).

Climacteric women experience both mental and physical symptoms. Psychological support is essential. It brings comfort and understanding to patients and has a positive impact on symptom improvement. In addition, professionals should encourage healthy practices to ease symptoms. Physical activity and a balanced diet are part of a whole set of actions to improve health (BRASIL, 2008).

In addition, health literacy helps women to maintain their health during the climacteric period. For this to be effective, nurses must use tools such as lectures and campaigns within PHC to attract this population. The development of manuals and protocols for the care of climacteric women acts to perpetuate this ongoing education, updating the entire nursing team to care for the community (GARCÍA, 2019).

Regarding the level of misinformation about the climacteric, the study showed similarities with other surveys carried out in Brazil, in which women expressed a certain lack of knowledge about the distinction between the terminology of menopause and climacteric, with only popular knowledge of menopause being highlighted.

"[...] Have you ever heard of the menopause? Orchid 15: By my mother [...]" (Orchid 15)

"[...] we hear about it on television, right, but I don't know directly, I've never had any information about it [...]" (Rosa 20)

"[...] some people say menopause because people only understand it if it's like that. [...]" (Pleomele 2)

"[...] Researcher: Has a health professional, either a doctor or a nurse, ever explained to you about the symptoms, the treatments, what the climacteric is? Bromelia 10: My gynecologist. [...]" (Bromelia 10)

A study carried out by Alcantara *et al.* (2020) shows similar data. According to the research, when the participants were asked about the menopause and the climacteric, it was clear that many did not know the difference and understood these terms as synonyms. The same study also shows that, in addition to their lack of knowledge, these women experience frustrations, insecurities and fears about their bodies and their femininity.

The Brazilian Federation of Gynaecology and Obstetrics (FEBRASGO) defines climacteric syndrome as a set of physical, psychological and social changes, while menopause is characterized after 12 months of amenorrhea. In this way, spreading knowledge about these periods helps women's quality of life during senescence.

CATEGORY B - INFLUENCE OF SYMPTOMS ON QUALITY OF LIFE.

This category seeks to demonstrate, through the data collected, the relationship and impact of climacteric symptoms on the women interviewed.

During the survey, data was collected on the neurovegetative, neuropsychic, sexual and genitourinary vasomotor symptoms typical of the climacteric. Analyzing the data collected, it was possible to see that most of the women interviewed reported having the symptoms listed and it is clear that they have a direct influence on their quality of life.

"[...] I have pain in my leg joints, in my fingers, that's what affected me the most (Pleomene 2)

"[...] Sometimes I try to sleep and I manage to do it close to the time I get up and sometimes I even sleep but I wake up at dawn and I can't sleep anymore, I feel those waves of heat, it feels like I need to go to the shower right away, then it feels like my brain turns on a 500,000 watt light bulb and won't turn it off to go back to sleep, so what do I do, I sit in bed and go meditate. [...]" (Palmeira 19)

The climacteric involves women's physical, mental and social health. In this line of study, the previous category explains women's lack of knowledge, which justifies the present category, which shows that symptoms linked to lack of knowledge about the climacteric influences women's health in an integral way.

Analyzing the data collected, it is possible to see that when the women were asked about the physical symptoms of the climacteric, such as vertigo, hot flushes, palpitations, insomnia, dysuria, among others, the majority said that they do have these alterations, while others reported that they had never had them or not yet.

"[...] I get insomnia, chills more at night which I mistake for night sweats, it's very uncomfortable. [...]" (Maranta 18)

"[...] Researcher: Do you sweat a lot, do you get very hot? Pleomene: No, just like the women say, for me this is the biggest thing, this climacteric thing is a surprise, I didn't think it was like this, I just saw people talking about it, right, but I'm normal, now that it's hot, but I don't have these things. [...]" (Pleomene 2)

The study by Costa *et al.* (2022) shows how symptoms affect women's quality of life using the Kupperman Menopausal Index (KMI), which classifies the intensity of symptoms as mild, moderate and intense. It also relates the practice of physical activities to minimizing symptoms. This is evidenced by the fact that women who practice physical activity for more than 150 minutes a week have a 61% chance of not having a lower quality of life during the climacteric period.

Following the analysis of symptoms in relation to sexual life, the field research showed that due to the climacteric and other issues, there is a decline in the quality of sexual relations. Both endocrine factors and the type of relationship with their partners influence the development of healthy relationships that contribute to well-being.

It is noticeable that the women studied lack the knowledge to relate the symptoms raised to the climacteric period, as well as forms of treatment that are not just focused on the complaint but on the whole process. However, it also shows a lack of openness on the part of health professionals when it comes to treating sexual dysfunctions in this age group.

"[...] Researcher: Do you feel pain or burning during intercourse, do you feel a lack of lubrication? Alocasia 17: I feel pain because... I don't cum, it's dried up inside me, then he tells

me to go to the doctor to get this and that because I'm young and I'm still going to feel pleasure, but I'm ashamed, I don't even have the courage to call my girl to go, I don't know how I'm telling you this here... [...]" (Alocasia 17)

During the climacteric period, sexual changes are one of the main symptoms due to the reduction in hormones. Many women often complain of dyspareunia, which affects their quality of life and especially their relationships with their partners. The compulsory nature of sexual intercourse imposed by society undermines women's satisfaction during sex and takes away their autonomy over their own bodies. Thus, women associate intercourse as a duty and not as something to get pleasure from (FONSECA *et al.*, 2021).

According to a study carried out by Gonçalves *et al*. (2023), during the climacteric 29.6% of the women interviewed reported having some kind of sexual dysfunction during this period. In addition, the social determinant of schooling was also linked, since women with a low level of schooling had higher levels of sexual dissatisfaction than those with a high level of education.

In the analysis of the mental health of climacteric women, it was observed that complaints such as sadness, anxiety, mood swings, self-perception factors such as self-esteem and intrapersonal relationships, among other alterations, were present in the speech of the participants.

"[...] Researcher: Have you noticed any changes in mood? Daisy 23: Too much, I'm 46, I feel like I'm 60, those boring old women who can't stand noise. [...]" (Daisy 23)

"[...] Researcher: Have you noticed any changes in your mood? Do you get very nervous? Sunflower 26: I get very upset. Researcher: Do you feel anxious? Sunflower 26: I don't know what anxiety is but I feel that I get very upset, but after I calm down I'm quite normal. [...]" (Sunflower 26)

"[...] Researcher: Have you had any mood swings? Begonia 29: All the time, even more so in the life I lead (laughs). [...]" (Begonia 29)

"[...] It's now that I think I feel uglier, every time I look, even if I close my mouth I still think I'm fat, everyone says I've lost weight, but I don't see it, it seems like the mirror is angry with me. [...]" (Maranta 18)

The lack of adequate knowledge about the importance and impact of mental health on quality of life is a factor that contributes to the lack of psychological interventions and treatments. During the climacteric period, mental illnesses can arise or be intensified due to hormonal and physical changes.

In the scientific article entitled "Relationship between mental health and climacteric adjustment in middle aged women: a confirmatory analysis", the authors conclude, after extensive research, that women who do not adapt well to the process of climacteric changes are more susceptible to psychological disorders. In addition, they state that health promotion within consultation and reception environments helps women during this phase (KHAKKAR *et al.*, 2023).

CATEGORY C - THE RELATIONSHIP BETWEEN SOCIAL DETERMINANTS.

This category aims to show the relationship between social determinants, such as schooling and economic conditions, and access to and knowledge about the climacteric and its symptoms.

In the course of the research, it was possible to see from the data collected that the level of education is a factor that has a direct relationship with health conditions, since it is at school that people have their first contact with

questions about quality of life. Of the women interviewed, 36.66% said they had incomplete primary education, 33.33% had completed secondary education and 23.33% had higher education. This shows the importance of this determining factor in these women's knowledge about their health.

"[...] I was really impressed about this pregnancy thing, because as I'm losing weight, I wondered if I got pregnant, after the operation and having my uterus removed, is there any danger, my God. [...]" (Gérberas 12)

"[...] I'm already taking medication that I researched on google, why don't I go to the doctor. [...]" (Alocasia17)

"[...] It's that old saying, isn't it, I used to be ignorant, like ignorant people I guess, I don't go to the doctor, right, but then in this "What I don't know I don't have" I already have psoriasis, my hair falling out, anemia, pre-diabetes, a lot of things, you know? And I let it all pile up at once and there's a psychological problem. [...]" (Daisy 23)

"[...] Why do I have so many children? I got married when I was 14, the father of my children was 14, two children living together [...]." (Jiboia 16)

The climacteric affects each woman in a unique way, which is why its symptoms should not be analyzed merely as a reduction in hormones, since socioeconomic and cultural factors also determine this period. Schooling, in turn, affects this process from the moment it gives women access to health services and, with this, guidance on the physiology of the climacteric and autonomy over its treatment (COSTA *et al*., 2022).

The research carried out in 2023 entitled "Knowledge about the menopause according to middle-aged Brazilian women: a population-based study" showed that women's schooling and social class influence their health knowledge. This is because access to information and education is a pillar for acquiring knowledge about quality of life, pathologies and treatments (AMARAL, 2018).

In the current study, during interviews, the women mentioned determining factors that influenced their progression through the climacteric process. In this context, the issue of income showed that some women, when asked about seeking other therapeutic options during the climacteric period, said "now the condition is not favorable".

In addition, the number of children and the lack of help with daily demands put a physical and mental strain on them. The participants reported a lack of time to look after their own health and also said that they neglected their own care for the sake of their family's health.

"[...]Yeah, my ex-husband lives in my house, and since he's very old, 83, he has diabetes, sores, high blood pressure, a lot of things, so the girls decided to let me take care of him. It puts too much strain on me, so I already have my son and he has him, you know." (Dracena 8)

"[...] We feel that obligation, don't we? We have to do everything on time, we have to do this and that, but we don't look after ourselves, do we?" (Lotus 22)

"[...] Lately I don't even think about myself, only about other people. Today I came here in a hurry, but my girl said I had to go to look after the kids, but then I said I couldn't make it today. [...]" (Dracena 8)

In the social context, women are seen as the support of the entire family network on the grounds that it is their "natural job". However, as Federici (2015) mentions, "The social di-

vision of labor needs to be transformed and, above all, reproductive work needs to be recognized as work." In other words, the act of caring must be understood as a valid function that creates an overload for the person who is placed in this role.

Within the context of social determinants, still talking about income, the practice of physical exercise is a factor that is influenced by this coefficient, since these are socially elitist practices that require time and money. During the research, there was a lack of participants who exercised regularly, justifying it by their exhausting routine and the impossibility of paying the costs.

"[...] Researcher: Have you ever thought about doing water aerobics? Xxxx24: My daughter has, but everything has to be paid for [...]" (Agave 24)

"[...] Where I go, I walk, but the routine is too intense to take time off to do other things because of these other health issues. [...]" (Palmeira 19)

"[...] Researcher: Do you practice physical activity? Violeta 1: No. Researcher: No walks? Violeta 1: No, I just work [...]" (Violeta 1)

In a study carried out in 2023 entitled "Access to bodily practices/physical activity during the life cycle: a report from retired elderly women", the interviewees reported that they did not receive encouragement in their childhood and adolescence to practice physical activity and, in their adult lives , they did not have the time, money or support. Thus, the participants stated that they were only able to do so after retirement (OLIVEIRA *et al*., 2023).

Maintaining well-being during all stages of life is a pillar for experiencing the climacteric period fully. Good lifestyle habits ensure that the dysfunctions characteristic of this time are mild and prevent the emergence of new pathologies that eventually arise in the aging process.

In this context, health centers represent an important factor in access to services that promote physical activity offered by the SUS. However, even if there are free centers, the incorrect division of housework leads to an exhausting routine that makes it impossible for these women to carry out other activities. Thus, gender inequality is also evidenced as a determining factor in women's health (OLIVEIRA *et al.*, 2023).

Enabling access to physical exercise promotes quality of life for all ages, but especially for climacteric women. Whether it's low-intensity sports, walking or even different types of anaerobic exercise such as weight training, the change in mood, intensity of symptoms and quality of sleep in this study population is notable.

FINAL CONSIDERATIONS

After analyzing and interpreting the interviews conducted, we believe that the results found allow us to answer the general objective of this research. It was observed that the climacteric period has a major impact on women's lives in all areas, although not always the same, psychological and physical symptoms always perpetuate on the patients' reality, making their interpersonal and intrapersonal relationships difficult.

The interviews revealed that women were unaware of this phase and of the therapeutic options available to them. Thus, many women go through all the symptoms without proper help, seek self-medication and even end up developing other psychological illnesses due to a lack of guidance on the physiology of their symptoms. We know that literacy and access to health information is something that needs to be improved in Brazilian society in order to guarantee quality of life, so that they

can carry on with all the functions that the community itself assigns to them as mothers, wives, housewives, as well as professionals in the job market.

This research shows that it is necessary to implement existing public policies to guarantee health promotion for climacteric women. Gynecological consultations should be focused on women's integral health and not just on a biomedical view. Qualified listening and emotional support help ensure that during the interview the patient feels that all her needs are met. However, the Ministry of Health's guidelines should be implemented, as well as the development of new protocols in the area to keep up with the evolution of techniques and guidelines.

We believe that the problem studied and the results found will be beneficial for promoting the health of climacteric women, bringing a new perspective to this part of the population. We also hope that this study will contribute to improving the health of these women, facilitating the transition from the reproductive to the non-reproductive phase and ensuring quality of life.

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