PROFILE OF WOMEN IN THE CLIMATERIC PERIOD LIVING IN A QUILOMBOLA COMMUNITY

PERFIL DAS MULHERES NO CLIMATÉRIO RESIDENTES EM UMA COMUNIDADE QUILOMBOLA PERFIL DE LAS MUJERES EN EL CLIMATERIO RESIDENTES EN UNA COMUNIDAD CIMARRONA

Adrienny Nunes da Silva Tavares¹, Ana Maria Almeida², Fátima Maria da Silva Abrão³, Aurélio Molina da Costa⁴

ABSTRACT

Objective: to identify the socioeconomic, demographic, clinical profile and life habits of climateric women living in a quilombola community. **Method:** This is a quantitative, descriptive, cross-sectional study developed in a quilombola community. A standardized questionnaire was used with 158 participants. A database was built in spreadsheet and the absolute and relative frequencies were calculated, and the results are presented in the form of tables. **Results:** it was observed that the majority of the women were brown, with stable companion and family income of up to two minimum salaries. It was pointed out that a third had no schooling, and a quarter of the menopause had its last menstruation between 38 and 42 years. It is noteworthy that more than a third of those surveyed had chronic disease, of which almost all were hypertensive, with or without associated diabetes. **Conclusion:** In this study, we identified the characteristics of a group of women in the climacteric of a quilombola community, and the lack of research on these communities, regarding the data investigated, makes the research original and relevant. **Descriptors:** Women's Health; Climacteric period; Menopause; Group with Ancestors of the African Continent; Population; Quality of Life.

RESUMO

Objetivo: identificar o perfil socioeconômico, demográfico, clínico e hábitos de vida de mulheres no climatério residentes em uma comunidade quilombola. **Método:** trata-se de um estudo quantitativo, descritivo, de corte transversal, desenvolvido em uma comunidade quilombola. Utilizou-se um questionário padronizado com 158 participantes. Construiu-se um banco de dados em planilha eletrônica sendo calculadas as frequências absolutas e relativas, e os resultados apresentam-se em forma de tabelas. **Resultados:** observou-se que a maioria das mulheres era parda, com companheiro estável e renda familiar de até dois salários mínimos. Apontou-se que um terço não tinha nenhuma escolaridade, e um quarto das menopausadas teve a sua última menstruação entre 38 e 42 anos. Ressalta-se que mais de um terço das pesquisadas portava doença crônica e, dessas, a quase totalidade era hipertensa, com ou sem diabetes associada. **Conclusão:** identificaram-se, neste estudo, as características de um grupo de mulheres no climatério de uma comunidade quilombola, sendo que a escassez de pesquisas sobre essas comunidades, no que se refere aos dados investigados, torna a pesquisa original e relevante. **Descritores:** Saúde da Mulher; Climatério; Menopausa; Grupo com Ancestrais do Continente Africano; População; Qualidade de Vida.

RESUMEN

Objetivo: identificar el perfil socioeconómico, demográfico, clínico y hábitos de vida de las mujeres en el climaterio, residentes en una comunidad cimarrona. **Método:** se trata de un estudio cuantitativo, descriptivo, de corte transversal, desarrollado en una comunidad cimarrona. Se utilizó un cuestionario estandarizado con 158 participantes. Se construyó una base de datos en hoja de cálculo y se calcularon las frecuencias absolutas y relativas, y los resultados se presentan en forma de tablas. **Resultados:** se observó que la mayoría de las mujeres eran pardas, con un compañero estable e ingresos familiares de hasta dos salarios mínimos. Se apunta que un tercio no tenía ninguna escolaridad, y un cuarto de las menopáusicas tuvo su última menstruación entre 38 y 42 años. Se resalta que más de un tercio de las investigadas portaba enfermedad crónica y, de esas, la casi totalidad era hipertensa, con o sin diabetes asociada. **Conclusión:** se identificaron, en este estudio, las características de un grupo de mujeres en el climaterio de una comunidad cimarrona, siendo que la escasez de investigaciones sobre esas comunidades, en lo que se refiere a los datos investigados, hace la investigación original y relevante. **Descriptores:** Salud de la Mujer; Climaterio; Menopausia; Grupo de Ascendencia Continental Africana; Población; Calidad de Vida.

¹Master, University of Pernambuco/UPE. Recife (PE), Brazil. E-mail: adriennynunes@hotmail.com ORCID iD: <http://orcid.org/0000-0002-2543-5663>; ²Nurse, University of São Paulo/USP. São Paulo (SP), Brazil. E-mail: amalmeid@erp.usp.br ORCID iD: <http://orcid.org/0000-0002-6398-7194>; ³Nurse, University of Pernambuco/UPE. Recife (PE), Brazil. E-mail: fatima.abrao@upe.br ORCID iD: <http://orcid.org/0000-0003-3254-2851>; ⁴PhD, University of Pernambuco/UPE. Recife (PE), Brazil. E-mail: aumolina55@gmail.com ORCID iD: <http://orcid.org/0000-0002-2641-7686>

INTRODUCTION

Afro-Brazilian black rural communities, known as quilombolas, have been known over time to become groups that resist external cultural influences and fight for social inclusion through actions of integral attention and the implementation of public policies. It is understood that, in this way, these groups generate demands considered major emergency issues of Brazilian society.¹⁻²

Among the various problems faced by these ethnic groups are: racial discrimination; extreme poverty; territorial invasions; migration to large urban centers; interference with culture, landscape and environmental balance; low household income and informal employment; the precarious housing conditions; the difficulty of access to health and education, durable and consumer goods and information; food vulnerability; institutional conflicts and the invisibility of the population.³

In the case of health, the reduction of social inequalities is one of the objectives of the Pact for Health, which considers as determining causes and determinants of health: ways of life; job; housing; environment; education; recreation; culture; access to essential goods and services, among others. In this sense, the creation of the National Integral Health Policy of the Black Population (NIHPBP) integrates actions and plans focused on the health care of this population, which persists under a framework of inequalities throughout history. Thus, the realization of the human right to health of the black population is also a milestone in the struggle for the establishment of ethno-racial and gender equity standards in the country's health policy.⁴

It is observed that, in relation to black women, it is traditionally below the poverty line, with difficulties in insertion in the labor market, illiteracy, headed families without spouses and with many children.⁵ In addition, there is restricted access to good quality health services, gynecological care and care in the pregnancy-puerperal period, making it more vulnerable to certain diseases, such as type II diabetes, arterial hypertension, uterine fibroids, sickle cell anemia, glucose-6-phosphate dehydrogenase deficiency, hypertensive syndromes during pregnancy, cervical cancer, and human immunodeficiency virus.⁴

There is a shortage of studies, when considering the black woman in the climacteric, about the characteristics of quilombola women and, consequently, the

lack of knowledge about the subject hinders the health actions directed to this ethnic group in this phase of life. It is therefore inferred from the lack of studies on these women that the health and care conditions may be related to the issue of race/color and the environment in which they live.

OBJECTIVE

- To identify the socioeconomic, demographic, clinical profile and life habits of climacteric women living in a quilombola community.

METHOD

This is a quantitative, descriptive, cross-sectional study. As a study scenario, a community located on the border between two states of the Brazilian Northeast, recognized as a quilombola by the Palmares Foundation.⁶ According to the association of residents of the village, there are currently about 800 families living in the community, in an area of about 17 hectares registered as private property.

The study was performed as a census evaluation, with a population consisting of all the women who were in the climacteric period (40 to 65 years of age) and who lived in the community. According to the Consolidated Family Register by Area (Report A2, extracted from the Basic Care Information System), there were 173 women who were contacted through home visits with the help of the community health agent (CHA) of each adsorbed micro area. A total of 158 climacteric women participated; the others (15) were not in the community during the collection period.

The socioeconomic, demographic, clinical characteristics and life habits of the women studied were investigated through a questionnaire used in a master's thesis on women in perimenopause and postmenopausal, and the author's use was authorized by the author.⁷

A database was built into a spreadsheet in the Microsoft Excel program, which was exported to SPSS software, version 17, and the absolute and relative frequencies were calculated.

The norms and guidelines of resolution 466/2012 of the National Health Council (NHC) regarding research involving human beings were respected.⁸

RESULTS

Table 1 shows the distribution of the socioeconomic and demographic profile of climacteric women evaluated.

Table 1. Distribution of the socioeconomic and demographic profile in climacteric women. Goiana (PE), Brazil, 2016

Evaluated factor	N	%
Age		
40 to 49 years	94	59.5
50 to 59 years	43	27.2
60 or more	21	13.3
Skin color		
White	14	8.9
Brown	76	48.1
Black	38	24.0
Yellow	5	3.2
Others	25	15.8
Education		
Without schooling	49	31.0
Incomplete elementary school	69	43.7
Complete elementary school	11	6.7
Incomplete highschool	3	1.9
Complete highschool	19	12.0
Incomp/comp Higher education	7	4.4
Conjugal situation		
Has a stable companion	113	71.5
Has an eventual companion	2	1.3
No companion currently	43	27.2
Occupational situation		
Active	69	43.7
House wife	68	43.0
Inactive	2	1.3
Retired	19	12.0
Family income		
1 to 2 minimum wages	146	92.4
3 or more	12	7.6
How many people depend on income		
Up to 2 people	54	34.2
3 to 5 people	79	50.0
6 to more people	25	15.8

Table 2 shows the presence of comorbidities, the use of medications and the clinical situation of climacteric women evaluated. The most frequent are female sterilization (tubal ligation), followed by cesarean birth, removal of the uterus (with or without removal of the ovaries) and restoration of the pelvic floor (perineoplasty).

Table 2. Presence of comorbidities, medication use and clinical situation in climacteric women. Goiana (PE), Brazil, 2016.

Evaluated factor	N	%
Has some kind of chronic disease		
No	101	63.9
Yes	57	36.1
Type of chronic disease one has		
Arterial hypertension	41	71.9
Diabetes Mellitus	4	7.0
Hipertension + Diabetes	12	21.1
Uses medicine		
No	91	57.6
Yes	67	42.4
Previous surgery		
No	45	28.5
Yes	113	71.5
Type of surgery*		
Sterilization	66	72.6
Caesarean	34	37.7
Hysterectomy	22	19.5
Perineoplasty	9	10.4
Others	20	21.7

* By the association of surgical acts, the total was greater than 113.

Table 3 shows the distribution of life habits investigated.

Table 3. Distribution of habits and practice of physical activity in climacteric women. Goiana (PE), Brazil, 2016.

Evaluated factor	N	%
Smoker		
No	152	96.2
Yes, up to 10 cigarettes per day	5	3.2
Yes, 10 to 20 cigarettes per day	1	0.6
Intake of alcoholic beverage		
No	153	96.8
Yes, once or twice a week	3	1.9
Yes, three or more times a week	2	1.3
Physical activity		
No	145	91.8
Yes once or twice a week	6	3.8
Yes, three or more times a week	7	4.4

Table 4 shows the distribution of the menopause situation in the women evaluated.

Table 4. Distribution of the menopause situation in climacteric women. Goiana (PE), Brazil, 2016.

Evaluated factor	N	%
Still menstruated		
Yes, no hormones	79	50.1
Yes, with hormones	4	2.5
No, no hormones	71	44.9
No, with hormones	4	2.5
Age of spontaneous menopause		
38 to 42 years	11	24.4
43 to 47 years	12	26.7
48 to 52 years	14	31.1
53 to 56 years	8	17.8

Table 5 shows the symptoms experienced by climacteric women evaluated.

Table 5. Distribution of symptoms in climacteric women. Goiana (PE), Brazil, 2016.

Current symptoms	N	%
Forgetfulness	101	63.92%
Joint pain (joint pain)	96	60.76%
Irritability	95	60.13%
Anxiety	92	58.23%
Headache	75	47.47%
Palpitation (fast heart)	72	45.57%
Sleep disorder (insomnia)	72	45.57%
Depression	70	44.30%
Decreased sexual desire	70	44.30%
Hot flushes	69	43.67%
Low physical disposition (fatigue, weakness)	69	43.67%
Muscle pain (cramp)	61	38.61%
Dizziness	53	33.54%
Sweating	52	32.91%
Vulvovaginal dryness	44	27.85%
Irregular spontaneous menses	28	17.72%
Pain in intercourse	28	17.72%
Others	12	7.59%

DISCUSSION

It is indicated, through the research findings, that quilombola climacteric women of the community of São Lourenço have a low socioeconomic and educational level. It is added, in relation to schooling, that the percentage of women with complete primary education (6.7%), in addition to being small, is lower than that found in a study carried out with quilombola women, in Minas Gerais, where 30.2 % had a schooling higher than nine years, that is, complete elementary school.⁹ It should be pointed out that registered

education is much lower than the national average (51%) observed for people aged 25 years or older, according to the Research National by Sample of Continuous Households 2016, known as PNAD CONTINUA 2016. It is important to highlight that the PNAD showed that incomplete schooling is more frequent among the black or brown population, when compared to the white population, as far as higher education is concerned (8.8% versus 22.2%), as for illiteracy (9.9% versus 4.2%).¹⁰ These findings suggest the educational precariousness of the quilombola community under analysis and how necessary it is an

effective commitment to change this sad reality.

In this study, the majority of those surveyed had a low income, not unlike the scenario found in a study carried out with 348 quilombola women from the State of Bahia, who identified that 74.7% of them had an income of less than half minimum wage.¹¹ It was found, in a study carried out with quilombola communities in the State of Goiás, that the majority had income around one to two minimum wages, both in the rural area (Quilombo Almeida) and in the urban area (Quilombo Jardim Cascata), this is 57.9% and 57.1% respectively.¹²

They point out that almost a third of those surveyed do not have a partner, the considerations made by a research that compared the positive and negative influence of the companion in the climacteric. It was found that, for the authors of the study, a cooperative and more understanding spouse reduces the stress load on the woman, considering the feeling of protection and emotional stability. The importance of the active dialogue between the couple and the educational interventions is also highlighted so that both understand the changes undergone in the climacteric.¹³

In this study, the percentage of women (93%) who claimed to be hypertensive, with or without associated diabetes, was higher than expected, according to the Ministry of Health, for menopausal women (80%), it is worth noting that according to the 6th Brazilian Hypertension Directive (BHD), hypertension is twice as prevalent in brown and black individuals, and among women, the disease is 130% more frequent than in white women.¹⁴ This chronic disease was also highlighted in a survey of 200 climacteric women between the ages of 40 and 65 enrolled in the Climatério Outpatient Clinic of the University of Caxias do Sul (UCS) Foundation, reported by 60.5% of those surveyed.¹⁵ These findings are considered relevant and worrying, since systemic arterial hypertension, a chronic and multifactorial disease, is characterized by a constantly elevated blood pressure within the arteries, which causes damage to the walls of blood vessels and functional and/or structural alterations of the blood vessels. target organs, with high morbidity and mortality, especially when associated with Diabetes Mellitus, obesity and altered levels of blood lipids.¹⁶⁻⁷

A large percentage of women who underwent tubal ligation, perhaps due to the context of the 1980s and 90s of the last century, were found to have been the main contraceptive method in Brazil, especially

between the population. It is known that in 1986, 28.2% of women aged 15-44 years were surgically sterilized, a proportion that increased to 40.1% in 1996 among women aged 15-49. In the midst of these findings, either a free choice for a definitive and effective contraceptive method or the lack of access to other methods, or the result of a successful population control policy, even with a racist bias.

According to the Nurses' Health Study, the risk of death is 5.5 times higher in smokers who use 25 cigarettes/day, compared to smoking to the non-smokers.¹⁹ It is emphasized that the almost absence of smokers in the sample analyzed is undoubtedly promising, since this number (6%) is almost half that found in the National Health Survey 2013 (11%). It is understood that this finding is worthy of new investigations, particularly with qualitative methodology, since the better understanding of this context can subsidize and optimize the preventive and educational measures already in progress or the accomplishment of new actions.

It is important to note that, with regard to the lack of physical exercise, many women have reported that daily exhaustive work (both on and off the mangrove swamp and the collection of shellfish) makes it difficult to perform physical exercises on a regular basis. It is noteworthy that, in fact, because of these labor activities, women considered themselves sufficiently active and, not, sedentary people. It is important to highlight that research and literature reviews indicate that regular physical activity contributes to preservation of muscle mass, increased joint flexibility, reduced somatic symptom intensity, and generates a feeling of greater well-being in the climacteric.²¹

It was also observed that almost all women did not use hormonal treatment to reduce signs and symptoms of climacteric. It was concluded that in a study with 85 climacteric women attended at the medical specialties clinic of the Health Care and Professional Practices Center (HCPPC), in the city of Montes Claros (Minas Gerais), that socioeconomic indicators correlated directly to non-climacteric use of hormonal therapy, raising the hypothesis that low socioeconomic and educational level may be a causal factor for a low use of this form of treatment.²² It is suggested that the finding of this research with quilombola women can also be explained by the fact that many of them were in the initial climacteric, or because they were unaware of this possibility, or perhaps

because of fear about the risks of hormone therapy, or, still, due to the difficulty of access to specialists, a context that also deserves a specific qualitative research.

It is noteworthy that, although the age of the last spontaneous menstruation was well distributed between the interval of 38 to 56 years, it is pointed out the percentage of women who reported that their menopause occurred in the range of 38 to 42 years, that is, at a young age. This is a cause for concern, as the long-term consequences of premature menopause include adverse effects related to cognition, mood, cardiovascular problems, bone health, sexual health, and an increased risk of early mortality, 23 and this relatively early menopause may have autoimmune causes, iatrogenic or related to changes involving the X chromosome.²⁴ It is indicated, through these results and their implications for the health of the studied population, the need to investigate, with speed, which variables may influence the fact under analysis, including the psychosocial and environmental aspects.

It is observed that, in relation to the main climacteric symptoms, the findings are in agreement with the literature, there are doubts about the relationship between symptoms, such as forgetfulness and irritability, and estrogenic decline, or psychosocial and organic factors related to the aging process. It was pointed out, however, in a meta-analysis that this period of women's life is really a time of cognitive decline and increased risk for depression, and that memory problems do seem to be associated, in addition to the connected factors to aging, to changes in the hormonal levels that occur in the climacteric, indicating that this theme is still worthy of further studies, including to subsidize specific interventions.²⁵

In a recent study of 8,000 women of varying ages, the view that the hormonal changes of menopause worsen the symptoms of rheumatoid arthritis and contribute to functional physical decline has been endorsed as regards complaints of joint pain, a relationship between estrogen levels and changes in joint inflammation, although the mechanisms of this association are not yet well defined.²⁶ However, the high prevalence of these painful complaints in this study can be related to previously undiagnosed sickle cell anemia (SCA). It is known that SCA is a hereditary disease caused by a mutated hemoglobin linked to the progeny of populations originating, mainly, in sub-Saharan Africa, and that may present clinical

manifestation of chronic or acute pain, intense or not, and chronic organic tissue damage and progression due to venous stasis and hypoxia.²⁷ It is indicated, as another hypothesis to explain this finding, the heavy and exhaustive work of these women in the mangroves, which could also contribute to the emergence of the joint pain reported by the interviewees.

CONCLUSION

The socioeconomic, demographic, clinical and behavioral characteristics of a group of women in the climaterium of a quilombola community were identified by this study, and the lack of research on these communities, particularly with regard to the data investigated, this original and relevant descriptive research.

It reinforces, through the results, the need to implement the attention focused on the health of quilombola climacteric women, with health professionals duly trained and sensitized to the peculiarities inherent to this population group. It is pointed out that the health needs of these women could be solved in primary health care through health education and consultations directed to this phase of their lives, and that Nursing professionals can have a fundamental importance in this process of prevention and health promotion of this population.

It is suggested that the results obtained in this study can be used as subsidies for specific strategies in the policy of attention to quilombola women, valuing and respecting their specificities and historical process. It is also argued that information gathered in the quilombola community of São Lourenço should stimulate the development of future research on the impact of the climacteric syndrome on the quality of quilombola female life, for the development of public policies that favor self-care and improvement of health care in their aging process, contributing to more resolute actions in the face of the aggravations experienced by them and, also, giving greater visibility to quilombola women.

Finally, it is necessary to intervene, including compensatory policies, to improve the socio-economic and educational profile of quilombola women.

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Corresponding Address

Fátima Maria da Silva Abrão
Rua Arnóbio Marques, 3010
Bairro Santo Amaro
CEP: 50100-130 – Recife (PE), Brazil