

Gender constraints in the production of demands by middle-aged women

Condicionantes de gênero na produção de demandas de mulheres de meia-idade
Condicionantes de género en la producción de demandas de mujeres de mediana edad

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Abstract

Objective: To analyze gender conditions present in middle-aged women's health demands from their daily lives.

Methods: This is a study with a qualitative approach of the Convergent Care Research type. The survey was conducted with two groups of participants: middle-aged women and health professionals. In total, 13 middle-aged women and 18 health professionals participated. The production of empirical material took place through reflection workshops and interviews in May and June 2017. Data analysis was performed using the discourse analysis technique.

Results: The results formed two empirical categories in which the position of the two groups of participants converge: *Gender attributes defining emotional demands in middle age*; *The body as an instrument of doing and demanding care in middle age*. The reported life experiences are marked by housework and family care and express emotional and physical burdens accumulated over the years. Health professionals reveal sensitive listening to women's demands; however, structural issues related to the organization of care hinder more resolving practices.

Conclusion: The results revealed that the daily life of middle-aged women defines demands for care linked to gender attributes, incorporated into daily life in a naturalized way. Without shared responsibilities in the family environment, there is a physical and emotional burden that prompts care. The health services recognize this, but there are only punctual actions for demands of a biological order and no systematic proposal for working with women that open paths to empowerment.

Resumo

Objetivo: Analisar condicionantes de gênero presentes em demandas de saúde de mulheres de meia-idade oriundas do seu cotidiano.

Métodos: Estudo de abordagem qualitativa do tipo Pesquisa Convergente Assistencial. A pesquisa foi realizada com dois grupos de participantes: mulheres de meia-idade e profissionais da saúde. No total, participaram 13 mulheres de meia-idade e 18 profissionais de saúde. A produção do material empírico se deu por meio de oficinas de reflexão e entrevistas nos meses de maio e junho de 2017. A análise dos dados foi realizada por meio da técnica de análise de discurso.

Resultados: Os resultados conformaram duas categorias empíricas em que convergem a posição dos dois grupos de participantes: Atributos de gênero definindo demandas emocionais na meia-idade e o corpo como

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instrumento do fazer e demandante de cuidado na meia-idade. As experiências de vida relatadas são marcadas por trabalho doméstico e cuidado da família e expressam sobrecargas emocionais e físicas acumuladas ao longo dos anos. Profissionais de saúde revelam escuta sensível às demandas das mulheres, contudo questões estruturais, ligadas à organização da atenção dificultam práticas mais resolutivas.

Conclusão: Os resultados revelaram que o cotidiano de mulheres de meia idade define demandas para o cuidado vinculadas a atributos de gênero, incorporados ao cotidiano de modo naturalizado. Sem responsabilidades compartilhadas no ambiente familiar, há sobrecarga física e emocional que suscitam cuidados. Os serviços de saúde reconhecem, mas há somente ações pontuais para demandas de ordem biológica e nenhuma proposta sistematizada para um trabalho com mulheres que abram caminhos ao empoderamento.

Resumen

Objetivo: Analizar condicionantes de género presentes en demandas de salud de mujeres de mediana edad originarias de su cotidiano.

Métodos: Estudio de abordaje cualitativo del tipo Investigación Convergente Asistencial. La investigación se realizó con dos grupos de participantes: mujeres de mediana edad y profesionales de la salud. En la totalidad, participaron 13 mujeres de mediana edad y 18 profesionales de salud. La producción del material empírico se realizó a través de talleres de reflexión y encuestas en los meses de mayo y de junio de 2017. El análisis de los datos se realizó por medio de la técnica de análisis de discurso.

Resultados: Los resultados conformaron dos categorías empíricas en las que convergen la posición de los dos grupos de participantes: Atributos de género definiendo demandas emocionales en la mediana edad y el cuerpo como instrumento del quehacer y que demandan cuidado en la mediana edad. Las experiencias de vida relatadas están marcadas por el trabajo doméstico y el cuidado con la familia y expresan sobrecargas emocionales y físicas acumuladas a lo largo de los años. Profesionales de la salud revelan una escucha sensible a las demandas de las mujeres, sin embargo, cuestiones estructurales, relacionadas con la organización de la atención dificultan las prácticas más resolutivas.

Conclusión: Los resultados revelaron que el cotidiano de mujeres de mediana edad definen demandas con el cuidado vinculadas a atributos de género, incorporados al cotidiano de modo naturalizado. Sin responsabilidades compartidas en el ambiente familiar, hay una sobrecarga física y emocional que suscitan cuidados. Los servicios de salud reconocen, pero existen solamente acciones puntuales para demandas de orden biológico y ninguna propuesta sistematizada para un trabajo con mujeres que abran caminos hacia el empoderamiento.

Introduction

In all periods of life, women have health demands that are neither universal nor restricted to physical and/or psychic-emotional dimensions, inserted in a social and cultural dynamic. It is up to the professional teams to be sensitive and prepared to recognize and respond to health demands - a fundamental premise for comprehensive care.

Historically, women's health care has focused on the reproductive period and, only recently, has some importance in the non-reproductive periods, especially for the elderly.⁽¹⁾ However, care for middle-aged women remains underestimated in Brazil and in other countries around the world, even in the context of primary care.^(2,3)

The sociocultural construction of women, allied to the valorization of their role as reproductive and caregivers, sustains and, at the same time, is reinforced by the production of socially designed spaces for women that can silence demands aimed at women's leading role, self-care and autonomy.

The absence of a multidimensional perspective in the approach to female middle age contributes to homogenize experiences, creating symptoms common to all women, denying their diversity and dis-

respecting cultural and experiential issues, including gender bias.

Gender is a socio-historical-cultural construct that favors the recognition of power asymmetries between men and women, including hierarchical social roles that compromise women's lives.⁽⁴⁾ Such recognition makes it possible to avoid reducing the demands of middle-aged women to clinical manifestations related to the transition from the reproductive to the non-reproductive stage, to menopause and/or menopause, and to favor the quality of care provided.

It is necessary to focus on care from a philosophical perception that allows us to care in a congruent and integral way, which permeates planning, organization and development of care through direct and constant interaction with middle-aged women, in order to mobilize them, encourage their participation and involve them in self-care and in promoting their health.⁽⁵⁾

A review study that investigated factors that influence a healthy experience of middle-aged immigrant women, classified them into three categories: personal factors, family factors, and community and social factors. Personal factors included income and employment, physical and psychological

health, perceptions of menopause, and acculturation. Family factors involved partner support, relationship with children and balance between family, work and personal duties. Community and social factors included social network, health services, traditional cultural expectations and discrimination in host countries.⁽⁶⁾

Thus, considering that women's life conditions and experiences are important subsidies for the promotion of comprehensive care, a broader research, which studied health demands in the experience of middle-aged women, revealed that these are presented in multiple dimensions, being presented in this article those resulting from gender conditions in the production of demands arising from their daily lives.

Given the above, we sought to answer the following question: What gender conditions are present in the production of demands of middle-aged women coming from their daily lives?

Therefore, this study aimed to analyze gender conditions present in middle-aged women's health demands from their daily lives.

Methods

This is a study with a qualitative approach of the Convergent Care Research type, which is characterized by uniting research with care actions that seek to improve and innovate the context of nursing and health care. It is a research method that allows the construction of knowledge combined with its application to promote changes or innovate care practices in dialogue with participants.⁽⁷⁾

The research is conducted and presented in accordance with the criteria defined by the Consolidated Criteria for Qualitative Reporting Research (COREQ).

The research was carried out in a municipality located in the southwest region of Bahia. The production of empirical data took place in the context of primary care, specifically in a unit of the Family Health Strategy and in the Family Health Support Center, chosen because they constitute a space for women's health care. This unit is a field of practice

of the teaching action of one of the researchers with undergraduate nursing students in the context of teaching, research and extension and is located in a peripheral neighborhood recognized by social vulnerability.

The study involved two groups of participants: middle-aged women and health professionals. In relation to women, the inclusion criteria were: being in the age group from 45 to 59 years old, being a Family Health Strategy user and as an exclusion criterion: being pregnant, considering that the experience of pregnancy can engender specific health demands related to pregnancy. For health professionals, the inclusion criteria were: being a professional from the Family Health Strategy or the Family Health Support Center and developing health care actions for women aged 45 to 59 years for at least 03 months. The exclusion criteria were: being on sick leave. In total, 13 middle-aged women and 18 health professionals participated in the survey.

The production of empirical material took place through reflection workshops and interviews in May and June 2017.

Reflective workshops are discursive practices through which participants make sense of experienced phenomena and position themselves against them.⁽⁸⁾ In our study, the workshops were about female middle age and health demands during this period. Before starting the workshop, participants filled out a form with socioeconomic data. Two workshops were held with health professionals and four workshops with middle-aged women. The mean duration of the workshops was three hours, with a snack break.

The speeches were recorded, transcribed in full and organized in the form of a narrative, later, they were examined in order to identify relevant aspects directed to the research objectives, which generated a synthesis and enabled the selection of five women for an interview, as the need to deepen the themes of their reports was identified. The selected women were invited to participate in the interview, which was carried out on a date and time previously agreed in a reserved room at the health unit.

Thus, the private interviews were an opportunity to actively listen to the care needs highlighted by women during the workshops, in addition to having enabled to deepen and complement information related to the object of study.

The simultaneous relationship between research and care, characteristic of Convergent Care Research, was established in the collective process from the exchange of knowledge and experiences between participants through interactive processes and encouragement provoked during data production, which occurred in the end, with reports already recorded to constitute empirical material.

The adoption of a participatory methodology for the production of empirical material made it possible to mobilize research participants' experiences and knowledge with a view to building and exchanging knowledge. The interview, carried out with the selected women, was also a useful space for research-care convergence, as it was triggered by the identification of research participants' demands.

Analysis of the empirical material was performed using the Fiorin discourse analysis technique. For the aforementioned author, discourse is a social position and the ideological mechanisms that produce it are materialized in language and can be studied through syntactic and semantic mechanisms for the production of the meaning of something dialogically produced. In discourse analysis, the socio-historical context of its production is considered. When adopting this analysis technique, we follow the following steps: 1) Exhaustive reading of the text to identify concrete (figures) and abstract (themes) semantic elements that conform to the same meaning plane; 2) Grouping of data according to the convergence of significant elements; 3) Understanding the central themes; and 4) Formation of empirical categories.⁽⁹⁾

The research was conducted in accordance with Resolution 466/2012 of the Brazilian National Health Council (*Conselho Nacional de Saúde*), being approved by the Institutional Review Board of the *Universidade do Estado da Bahia* (UNEB) in

2017, under Opinion 2,063,533. To ensure anonymity, participants were identified with alphanumeric characters. To indicate middle-aged women, the letter P was used and to designate professionals, the letters PS, followed by Arabic numerals. The abbreviations corresponding to the technique that enabled the recording of women's speech, workshops (W) and interview (I) appear at the end of each speech.

Results

The middle-aged women who participated in the research were in the age group between 45 and 58 years old, five were illiterate, four had complete or incomplete primary education, three completed high school and one completed higher education. Ten declared themselves brown, two declared to be black and one declared herself white; seven women were married or in a stable relationship, five were divorced or separated and one was single. Ten reported being Catholic and three reported being Evangelical.

Regarding professionals, the group consisted of a nurse, dentist, physiotherapist, physical educator, nutritionist, social worker, community health worker (seven), nursing technician (two), pharmacy assistant, oral health assistant and receptionist. One of the nursing technicians has a degree in nursing, five community workers are taking a degree in social work and one is a graduate in pedagogy. Seventeen professionals were female and one male. The age range was from 31 to 57 years old. Nine of the professionals were in middle age (45 to 59 years). As for race/color, four people declared themselves white, six brown, six self-declared black, one self-declared yellow and another professional did not report.

The life experiences reported by middle-aged women who participated in our study are marked by housework and family care and express emotional and physical burdens that have accumulated over the years.

The speeches of health professionals, who also participated in the study, reveal a sensitive listening

to the demands of women and articulate them with the social context in which they operate; however, structural issues, linked to the organization of care, hinder more resolving practices.

The results formed two empirical categories in which the position of the two groups of participants converge: *Gender attributes defining emotional demands in middle age*; *The body as an instrument of doing and demanding care in middle age*.

Gender attributes defining emotional demands in middle age

The category of gender attributes defining emotional demands in middle age results from the observation that cumulative physical and emotional burdens are a part of these women's daily lives, generating wear and tear and compromising their well-being and self-esteem. This reality is reflected in the following statements:

I'm so busy and nobody listens. No one gives a cuddle. That's a loneliness. You're in the middle of your family, in the crowd and you're feeling lonely. You have so much to do and you can't handle it (P8, 45 years. W).

The other day a thorn entered into my hand [...]. I had to do the dishes, I cried, I whined. I only have God. I have my mother in the wheel chair. I need to take care of her Sunday day [...]. I had to hold that hand up because I couldn't take pain [...]. But I always feel so lonely (P5, 56 years. W).

I wanted, therefore, that they [the children] really look at me [...]. They're all grown up, but I have to fight [...]. If they get sick, I have to take care [...]. I did everything for them and today, they do nothing for me, understand!? [...]. I'm not a bad mother. Because I was their mother and father (P7, 50 years, I).

Health professionals, in turn, stated that women dedicate their time and concern to domestic work, while neglecting their self-care:

At this age, many women here that we care for [...] think that they have to live long for their chil-

dren, husband. A lot of people work outside work indoors. They are the ones who, in this case, are the support of the family and forget to take care of themselves. They think that their lives are meaningless, that they live even for a son, for a grandson, for husbands (PS15).

These women they think they don't have it anymore...so they're not important, they don't take care of themselves. They think they don't have to get ready anymore, to get out. Many end their sex life. They think it's no longer part of their lives (PS17).

The aspect of loneliness is also portrayed by health professionals, who demonstrate a sensitive look at the context in which users experience their experiences. Thus, they state:

The woman at this stage feels a little lonely, because the children are already married. Then she feels alone at this moment, sometimes without the support of her children. And also, she ends up taking responsibility for her grandchildren [...]. She stays there all day with her grandchildren (PS16).

In this middle-aged age group, women really need to be heard, because, so the family, sometimes, because she is already in this phase of caring for a grandchild, staying at home for household activities [...] she does not listen. She comes in and out and do not sit a little to talk to them, because she has all the needs of any other woman and still has a more special need because of her age group (PS17).

They love coming to the unit. Many times, I pass by the house [...] or my colleagues pass by, they say "I needed your visit so much. "How did you guess I needed the visit today?" They let off steam. We don't write anything we have to write. We just listen, talk. A lot of times, we stay with that person all afternoon. A lot of times, you go out to make eight visits and you end up doing three, two during the day. Why? Because they just want to be heard, that we listen to them (PS9).

Attentive to the demands of women, professionals offer physical activities that link them to the service. They reinforce that the life context in which they are located is considered for their actions in the health unit and for working with specific groups of middle age, as reported below:

Thinking about these women that we follow day by day [...] they are not only there to do physical activity, but for the attention, the listening they need... a differentiated look [...]. When they arrive here in the group [...] they have the need to be heard, to have someone to talk to. "If there is no activity, there is no problem, but we will come here so that we can talk to each other [...]. They need a differentiated look, a welcome, a listening. We in primary care bring to these women, in addition to daily orientation, in groups, in the waiting room [...] we professionals end up listening, listening to the demands (PS6).

They are not heard there at home with family members, but when they arrive here in the unit, those who seek unity... we need to form a specific group (PS17).

By narrating their experiences in care, professionals also reinforce the need for intersectoral actions in response to the demands of these women, represented in the following speech:

Women are in need of distraction, for fun. We work with the population that lives a lot with crime [...]. The government that has to take that responsibility. We in the family health program are not going to get this on our own. It's no use just forming a group. Another important thing for women in this age group is that most do not have a level of education. He can't read and write [...]. Here was the All for Literacy Program, [...]. What was happening there? Many claimed problems of sight. "Oh, I'm not going because I can't read" (PS1).

Moreover, being in the process of aging, for some women, refers to the finitude and a representation of loss of autonomy and the ability to do it by another person and by themselves:

I ask God to give strength, to keep me standing, that I don't want to stop. I want to stay always... moving my life. I worry [...] asking God not to happen. Because I'm getting weak, old, getting older. I see every day, I get even weaker. I don't like to grow old (P13, 52 years. WF).

One of the participants represents the fear of loss of autonomy in the face of limiting disease, glaucoma, more frequent in the age group studied, and divine protection is the support every day, as stated:

It's been five years since I've found that I have very advanced glaucoma [...]. I think so much about my grandchildren [...]. That's my fear. I at home and lose my sights [...]. Depending on others, right? [...]. I am very independent [...]. If I lose my sight of everything, what will become of me? Every day I wake up I ask God. God is giving me the vision (P10, 52 years. I).

In convergence with what women report, the speech of health professionals reaffirms that the construction of gender identity promotes in increasing movement a woman without the opportunity to perceive themselves. It also shows that when the service establishes dialogue and offers listening women find space to express their demands:

Most of them think it's right to take responsibility for others and forget about them. [...]. When you pull a little thread, they say it: "It's true. I don't exist!"; I've been taking care of my family, if there's a little time left..."; I don't take care of my health; I take care of others; I take care of each other's health. This is very sad (PS8).

The demands come from gender attributes incorporated for women and men, with emphasis on the responsibility for domestic activities in front of a husband who is not willing to share responsibilities, as shown in the statements of the users participating in the research:

There are hours when you want to go in a corner and you don't go because of your husband. You have to make food to leave it to the husband, tidy up the house, do the right things [...]. You have to worry about food for the husband (P1, 49 years, W).

We are alone doing things, we get nervous, we get stressed [...]. Because I get nervous, because I'm doing things and everybody's just looking. I clean the house and the man is coming and going [...]. Pressure goes up. I start feeling nervous (P4, 46 years, WF).

On the other hand, some women are resistant to putting themselves as people to be cared for and thus claim:

I don't like being taken care of. I like to take care of myself, that no one takes care of us if i don't go with interest in something. [...]. So, you doing your little things your way, every time you do a little bit is better than being taken care of by others, I think so. It is difficult for you to be cared for by others (P6, 51 years. WF).

The body as an instrument of doing and demanding care in middle age

This category reveals beliefs and values attributed to aging. Next to what is already incorporated as a demand for care in the health network, such as the prevention and control of diseases such as systemic arterial hypertension, cervical and breast cancer, participants highlight the appearance of pain as a mark of middle age, attributing them to aging:

Apart from the pains here, from there and from there, the little things of health, I have a quiet life today (P5, 56 years. W).

We get a lot of diseases. It's just pain, back pain, leg pain, etc. I'm experiencing back pain [...]. I feel a lot of pain in the legs, I have spur on both feet (P4, 46 years. W).

I feel pain from the tip of my finger to the lint of my hair. I feel a lot of pain in the body, pain in the arms, pain in the legs, pain in the back, pain in the spine, there is time that I am dead, even in the joints, in the fingers hurts [...] everything hurts (P13, 52 years. W).

I'm just feeling a pain in my spine that I'm not holding up. Feeling pain here in the fingers, in the joints, but that's a thing of age anyway. Age's coming. It's an age thing, we get old, there's so much coming up. When I was young, I didn't feel anything [...]. Now the pains have shown up (P4, 46 years. W).

I feel pain. I'm in pain in that foot here. I almost die; every day they even burn, mainly because I work at night standing [...] I'm with spur by the way, I cannot step on the ground (P7, 50 years. W).

Middle-aged pain is reported as a consequence of an accumulated physical overload and lack of adequate preparation for performing work, illustrated in the following reports:

Today, I have three herniated disk, I have hip wear, it was all an overload that I had no preparation [...] when we arrive in middle age we have the consequences (P8, 45 years. W).

I, when I clean, it's so much pain that, for me to sleep, I take a pill of a milligram of dipyron and apply gel on the feet. Otherwise, the pain bothers and does not let me sleep (P5, 56 years. W).

It hurts, I don't know if it's daily tiredness, I just know everything hurts. Some days I wake up by the force of God. The moment I put my feet on the ground, I'm stiff there, hamstrung. I say, "Sir, I need to walk, I need to work, I need help" Then I get up and I do my things [...]. It is "ouch" to get up, it is "ouch" to sit, but ball forward, with faith in God because it is God who sustains us [...]. (P13, 52 years. W).

One of the research participants reveals tiredness attributed to a cumulative routine of work overload:

I don't feel pain, just tiredness, it's different [...]. I feel tired. There are days I feel pain in my legs, in varicose veins, but more of tiredness [...]. In the week that I wash a lot of clothes and that I deliver, I feel so tired (P1, 49 years. W).

Despite the pain, the women participating in the research maintain so much work in an attitude of subjection and at the same time of resignation, they use “unconcerned” in the face of few prospects of resolution of their complaint:

Sometimes I start the day with a headache, I'll worry about me with that headache [...]. If I'm going to worry about that, it's going to be worse for me. And maybe if I get that out of my head if I worry. That heals that you don't even see [...]. If I disconnect from that, then ready, it's over, it healed [...] If you're going to worry about you [...] you get sick (P1, 49 years. W).

As with other public health system users, middle-aged women are not guaranteed access or resolution in the face of their clinical complaints. Some of them use their own resources for this purpose, represented in the following statements:

I'm feeling some back pain, I came for an exam with the doctor last week, the doctor asked me for an exam, the girls said it was not scheduled by the SUS, I had to pay, I brought it today, I showed it, there was nothing, he asked for others again (P4, 46 years, W).

I myself have a heart electro; I think you have about three months, you have about five months already; if you have a problem in your heart, when you come to do (the test), if you have to die, you already died (P1, 49 years, W).

Some participants react to pain, seeking physical activity as a measure that promotes relief and report this benefit without drug therapy use:

I exercise there relieves the pain a little. I don't take pain killer at all, not because I know it doesn't heal. (P13, 52 years, W).

We are doing physical activity here every Wednesday [...]. It improves pain, is good for the body [...]. (P5, 56 years, W).

I've been doing water aerobics for over three years, I've improved a lot because I've been without working for five months, away, I've been in bed for more than a month, the doctor said I was going to be in a wheelchair and after a lot of effort, physiotherapy and water aerobics, I'm fine today. (P8, 45 years, W).

In line with the reality verbalized by women, nurses, as part of the Family Health Strategy team that participated in the research, value integrative and complementary practices for pain relief, emphasizing the importance of acupuncture, while recognizing deficiencies in the service that does not incorporate other possibilities of care for middle-aged women:

Acupuncture is so important [...]. One user said, “After I did acupuncture, I stopped taking some medication.” She's improved her pain a lot. So, in my opinion, we should bring these alternative therapies and get out of that trivial. (PS1).

Professionals explain that the health services network cannot respond to the demands of middle-aged women, including disease prevention and control, provided for in ministerial programs. They evidence structural flaws related to the delay in being able to schedule and perform tests, difficulties in accessing medicines and care impaired by professional negligence:

If you need a supplementary exam, she's forgotten now. It's a year. I have even directed them to do private [...]. But most are unable to do [...]. The woman is greatly underestimated in care. Most importantly, lower-class women are greatly underestimated. The trivial and so on. Many

patients that I refer to gynecological assessment, return only with the clinical consultation [...]. So, it's these little details that are destroying the assistance (PS1).

There are prescriptions that the gynecologist gave that medicine and she did not buy, because she has no conditions and also because the unit does not offer this medicine [...]. So, she goes without treatment (PS16).

In these discourses, listening sensitive to women's demands and a careful look at the reality of practices reveal problems related to structural issues, related to the organization of care that hinder the provision of comprehensive care.

Discussion

It is emphasized that, although it is not intended to generalize, since it is a qualitative research whose sample size can be considered a limiting factor, the results presented refer to the experience of women in a specific context of economic and social vulnerability common to a large number of women.

The study offers important subsidies in the direction of comprehensive health care for middle-aged women, demonstrating the importance of considering the social dimension of the health-disease process and avoiding reducing women to a biological body. This is because, in the vast majority of studies on middle-aged women's health, their demands are centered on the physiological aspects of climacteric and menopause.

In the present study, physical and emotional overloads accumulated throughout life appeared as generators of wear and health impairment of middle-aged women. Throughout life, even without formal work, women almost always perform tasks fundamental to the family structure alone. The effort undertaken to perform everyday tasks within homes has negative implications for women's health and thus favors their illness.⁽¹⁰⁾

Thus, under almost exclusive female responsibility, domestic work is covered up and obscured

in family daily lives, invisible in the social, cultural and economic dimensions of society and devalued even by women themselves when they do not perceive it as work, but as a female obligation.⁽¹¹⁾

Factors such as age, marital status, number of children, family and leisure leadership, as well as the high volume of unpaid work, such as double work and the work of caring for the family, associated with emotional components, are considered as enhancers of women's psychological diseases.⁽¹²⁾

A study conducted in China showed that the burden of domestic work impacted on the formal work of middle-aged rural men and women, with regard to the lower amount of hours worked and production yield, with the most intense effects for women. Moreover, it found that care for family members and grandchildren directly interfered with quality of life, especially women.⁽¹³⁾

Psychological and social issues play a significant role in the higher prevalence of depressive and anxiety disorders among women in adulthood when compared to men in the same period of life. The traditional social role played by them exposes them to a higher level of stress and also makes them less able to change their stress-generating environment.⁽¹⁴⁾

A study carried out in Chile with middle-aged women who play many roles, mainly as the main caregivers in the family network, showed that being exclusively responsible for these demands was associated with dissatisfaction with life and lack of self-care.⁽¹⁵⁾ In another survey involving Brazilians and Portuguese, it was found that the effort to maintain marital satisfaction is a factor of emotional overload for women.⁽¹⁶⁾

The designation of women to the reproductive and domestic sphere and of men to the public and productive space has as principles the separation of work considered to be of men and women and its hierarchy. This incorporation of sexual roles is established from the learning of gender, that is, through a process of socialization that inscribes mechanisms in bodies and minds that legitimize this shared belief, in a movement in which the arbitrary is seen as a fact of nature.⁽¹⁷⁾

However, the research results also reveal that the exclusivity of women in the role of family caregiver confers powers, including in the formation of subjectivities, from the point of view of gender, adds value to them and, along with that, a representation of infallibility.

It is through domestic work that women weave networks of power in the family environment in their daily relationships in the performance of the role of educators and socializers in the family, demystifying the idea of their total submission to male power.⁽¹¹⁾

Thus, in the reality of the middle-aged women participating in this study, they are afraid of losing their autonomy in relation to doing things for themselves and for someone else, and they fear they need support, care and have no one to count on. This position reflects the socialization process of women of constant disposition to the other, demonstrating subjection and resignation to the responsibilities that are socially assigned to them.

A study with middle-aged African-American women, central caregivers at home and a family member in the process of becoming ill, showed that this assignment increases stress and anxiety and causes a decline in women's health and, consequently, contributes to the process of getting sick. In this study, women who had professional support in order to encourage their self-care felt less overloaded.⁽¹⁸⁾

Women's health care, in addition to reproductive demands, has required professionals to change practices and provide more humanized and qualified care. Knowing women's health conditions and psychosocial needs has become a priority for healthier female aging with better quality of life, in addition to favoring self-care.⁽¹⁹⁾

Even though many people are aware of the importance of modifying their lifestyle and promoting healthy habits, they are often unable to mobilize themselves to modify their lifestyle. Thus, one of the challenges for professionals who work with this audience is to encourage and facilitate access to healthy practices so that middle-aged people can adhere.⁽²⁰⁾

The perception of the aging process obtained in research shows in its results the concern of middle-aged people to grow old with autonomy and that the resulting demands be converted into actions aimed at ways of life that promote healthy and active aging.

When referring to demands related to the prevention and control of diseases such as hypertension, cervical and breast cancer, the incorporation of values related to disease prevention and control is confirmed, to which is added the search for health care in the face of biological, social and psycho-emotional pain, demonstrating how the offer modulates the demand. However, not even for the issues that are expressed in the biological, the health service network is resolvable, as pointed out by professionals and middle-aged women participating in the research.

Middle age pain appears in this research as a very common complaint and with few prospects for resolution. However, the women emphasize that they maintain the pace of housework and for pain relief, some refer to medication use, others only physical activity and others resort to "not worrying".

The experience of pain is part of a collectively elaborated field of meanings. Its expression is governed by cultural codes that are apprehended in the social environment from the first moments of socialization. Thus, the social place occupied can influence pain tolerance, since there are different sociocultural conditions that qualify the reality of pain in a society in different ways.⁽²¹⁾

In research on the experience with pain, greater femininity or female social roles were associated with lower pain thresholds and tolerance, as well as greater propensity to communicate the painful sensation regardless of the type of encouragement, ethnicity or sexual orientation.⁽²²⁾

In this sense, it is essential to care for middle-aged women, provision by the health service network of guided physical activity, physiotherapy and complementary therapies, as, in addition to having a positive impact on complaints of physical pain, it favors women's emotional and self-esteem.

Conclusion

The study results show the care demands of middle-aged women that are not restricted to a biological body, but to the multidimensional body, which has marks of each woman's history and social and gender inequalities. In summary, middle-aged women's daily life defines demands for care linked to gender attributes, incorporated into daily life in a naturalized way. Without shared responsibilities in the family environment, there are physical and emotional demands and burdens that prompt care. Health professionals recognize, but there are only punctual actions for demands of a biological order and no systematic proposal for working with women that open paths to empowerment. New research on female middle age and health demands from a gender perspective is considered important to expand knowledge in different contexts and favor the implementation of cross-cutting public policies for comprehensive care.

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Rodrigues LSA, Coelho EAC, Aparício EC, Almeida MS, Suto CSS and Evangelista RP collaborated with the study conception, data collection, analysis and interpretation, article writing, relevant critical review of intellectual content and final approval of the version to be published.

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