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Quality of life in the climacteric of nurses working in primary care

Qualidade de vida no climatério de enfermeiras atuantes na atenção primária

Calidad de vida en el climaterio de enfermeras que actúan en la atención primaria

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ABSTRACT

Objective: to evaluate the quality of life of primary care nurses in the climacteric. **Method:** A cross-sectional descriptive-analytic study, performed with 98 female nurses, aged 40-65 years, using the WHOQOL-Bref questionnaire. **Results:** the worst level of quality of life was observed for professionals aged 50-59 years, non-white, specialists, divorced or widowed, with children, a lower income, with another employment relationship, a weekly workload of more than 40 hours, who consumed alcoholic beverages weekly, with chronic disease, in continuous use of medications, sedentary, who did not menstruate and did not receive hormonal treatment, and who went through menopause between the ages of 43-47 years. **Conclusion:** Although the variables "physical activity" and "age" have a statistically significant association with quality of life, other variables seem to interfere in these professionals' lives, indicating the need for a more critical and deep reflection on these relations.

Descriptors: Climacteric; Nursing; Menopause; Women's Health; Quality of Life.

RESUMO

Objetivo: avaliar a qualidade de vida de enfermeiras no climatério atuantes na atenção primária. **Método:** estudo descritivo-analítico, de corte transversal, realizado com 98 enfermeiras, com idade entre 40 e 65 anos, utilizando-se o questionário WHOQOL-Bref. **Resultados:** apresentaram pior nível de qualidade de vida as profissionais com idade entre 50 e 59 anos, não brancas, especialistas, divorciadas ou viúvas, com filhos, com menor renda, possuidoras de outro vínculo empregatício, carga horária de trabalho semanal acima de 40 horas, que ingeriam bebida alcoólica semanalmente, portadoras de doença crônica, em uso contínuo de medicamentos, sedentárias, que não menstruavam e não faziam tratamento hormonal, e que apresentaram a menopausa entre 43 e 47 anos. **Conclusão:** apesar das variáveis "realização de atividade física" e "idade" terem uma associação estatisticamente significante com a qualidade de vida, outras variáveis parecem interferir na dessas profissionais, indicando a necessidade de uma reflexão crítica e mais aprofundada sobre essas relações.

Descritores: Climatério; Enfermagem; Menopausa; Saúde da Mulher; Qualidade de Vida.

RESUMEN

Objetivo: evaluar la calidad de vida de enfermeras en el climaterio que actúan en la atención primaria. **Método:** estudio descriptivo y de análisis, de cohorte transversal, realizado con 98 enfermeras, de entre 40 y 65 años de edad, en que se utilizó el cuestionario WHOQOL-*Bref*. **Resultados:** presentaron un peor nivel de calidad de vida las profesionales: de entre 50 y 59 años de edad, no blancas, con especialización, divorciadas o viudas, con hijos, con menor renta familiar, que tenían otro vínculo de empleo, con carga laboral semanal superior a 40 horas, que consumían alcohol semanalmente, portadoras de enfermedad crónica, en el uso continuo de medicamentos, sedentarias, que no menstruaban y no estaban bajo tratamiento hormonal, y cuya menopausia empezó entre 43 y 47 años de edad. **Conclusión:** a pesar de la variable "realización de actividad física" y de la variable "edad" haber presentado una asociación estadísticamente significativa con la calidad de vida, otras variables parecen afectar la calidad de vida de esas profesionales, lo que demanda una reflexión crítica y más profundizada sobre esas relaciones.

Descriptores: Climaterio; Enfermería; Menopausia; Salud de la Mujer; Calidad de Vida.

INTRODUCTION

The increase in life expectancy, leading to a greater number of elderly people, is an expression of the changes in the living standards of contemporary society and the modernization of technologies used in health care, both curative and preventive[1].

In Brazil, population data show the existence of around 207.7 million people, of which approximately 12.51% correspond to the elderly population that, according to the National Elderly Policy and the Estatuto do Idoso (Statute of the Elderly), are 60 years old or older. Of the total of this population segment, approximately 6.97% are represented by women and 5.54% by men[2]. These figures show that a significant number of women reach senility and, therefore, experience the climacteric, corroborating the view that this period deserves a differentiated "care look", also because its duration is similar to the reproductive lifetime[3].

The climacteric, according to the World Health Organization (WHO), is understood as the transition between the reproductive and non-reproductive period, marking the beginning of the aging of women. It is characterized by a decline in ovarian functions and, consequently, a decrease in the estrogen hormone, and should be considered a physiological period of the woman's life and not a pathological process. It occurs in all women, starting usually between 35-40 years, and can extend up to 65 years[4].

The climacteric syndrome, or menopausal syndrome, comprises the somatic symptoms and emotional difficulties that appear at this stage of the woman's life and may compromise her well-being[5]. Among the main complaints are vasomotor symptoms, such as heat waves in the body, also known as "hot flushes", accompanied or not by sweating (at night or suddenly), insomnia, urogenital and sexual symptoms such as vaginal atrophy, irregular bleeding, decreased libido and others resulting from hypoestrogenism, as well as psychological ones, all of which can directly influence quality of life (QoL)[6].

For the WHO, QoL is conceptualized as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns"[7]. Currently, there is a consensus that, for any intervention performed in the climacteric, it is also necessary to evaluate the QoL[8].

In this delicate period of female life, in which physiological changes require adaptations, both physical and psychosocial, there are other potentially negative variables, such as — in the case of health professionals, especially the female nurse — an extensive and stressful workload, which can make this phase even more physically and emotionally draining[9]. The nurse, recognized as the professional who is responsible for caring for people, may have her health compromised due to a large number of working hours and unfavorable living habits. However, the impact of this period on the QoL of female nursing professionals has been poorly evaluated and, perhaps, the nurse, despite being able to aid health services patients during this vital period, may not know how to deal with the health situation in her own life. Within this context, this research offers subsidies for interventions that promote improvements in the quality of life of nurses who are in the climacteric and that may also improve the labor actions in this period of their lives.

OBJECTIVE

To evaluate the quality of life of nurses who are experiencing the climacteric period and work in primary healthcare of a capital in the Northeast region of Brazil.

METHOD

Ethical aspects

According to resolutions no. 466/2012[10] and 506/2016[11] on research involving human subjects, this study was approved by the Research Ethics Committee in the Health Area of the University of Pernambuco, through submission in the Plataforma Brazil.

Design, location of the study and study period

This is a cross-sectional, descriptive-analytical study carried out in 68 family health units of the city of Recife, PE. The collection was performed on scheduled days, according to the nurses' preference, through individual interviews, after signing the Informed Consent Form (ICF), from January to June 2016.

Population or sample, inclusion and exclusion criteria

The study population consisted of 98 female nurses between the ages of 40 and 65 years old, working in primary care in the city of Recife, PE. The inclusion criteria were: to be within the age group and to be part of the professional staff of the Family Health Team (FHT) at the time of the interview. We excluded four oophorectomized (single or bilateral) professionals, two who underwent radiotherapy and chemotherapy for breast cancer and one for ovarian cancer.

Study protocol

Two instruments were used to collect the data. The first was a semi-structured questionnaire with objective questions for the characterization of social, demographic, economic and clinical data. The second instrument was the World Health Organization Quality of Life – Bref questionnaire (WHOQOL-Bref), applied in an individualized way through reading with the nurses. It is a questionnaire with objective questions about QoL in the physical, psychological, social relations and environment domains. It is a generic instrument, developed from the World Health Organization Quality of Life - 100 (WHOQOL-100), due to the need for a shorter questionnaire requiring less time to complete, validated and translated into the Portuguese language in Brazil, with wide use in climacteric women. It consists of 26 questions, the first two being general and the other related to each of the 24 facets that make up the original instrument. The responses follow a Likert scale (1 to 5, and the higher the score the better the QoL). The scores of the facets and domains were calculated on a scale from 0 to 100, in which the closer the value is to 100, the better the QoL assessment[12].

Analysis of results and statistics

The variables were processed and analyzed using the Epi Info software, version 3.5.2, and the SPSS, version 17. The Shapiro-Wilk,

Mann-Whitney and Kruskal-Wallis tests were used, considering a p-value <0.05.

RESULTS

Tables 1 and 2 show the distribution of primary care nurses according to sociodemographic, clinical, labor, menstrual variables and behavioral habits.

Table 1 – Distribution of sociodemographic and labor variables of the Family Health Team nurses, Recife, Pernambuco, Brazil, 2017 (N=98)

Assessed factor	n	%
Age		
40 to 49 years	54	55.1
50 to 59 years	32	32.7
60 years or older	12	12.2
Skin color		
White	46	47.0
Brown	44	44.9
Black	7	7.1
Others	1	1.0
Qualification		
Specialization	82	83.7
Residency	11	11.2
Master's degree	4	4.1
Doctorate	1	1.0
Marital status		
Single	19	19.4
Married/stable union	64	65.3
Divorced/widowed	15	15.3
Family income		
3 to 4 MW	4	4.1
5 to 7 MW	29	29.6
8 to 10 MW	43	43.9
11 MW or more	22	22.4
Has a child		
No	23	23.5
Yes, 1 child	25	25.5
Yes, 2 children	38	38.8
Yes, 3 or more children	12	12.2
Service time at the FHT		
Less than 10 years	14	14.3
10 to 20 years	76	77.6
Over 20 years	8	8.2
Further employment relationships		
No	38	38.8
Yes	60	61.2
Total workload		
40 hours	40	40.8
41 to 60 hours	15	15.3
Above 60 hours	43	43.9

Note: MW – Minimum wage; FHT – Family Health Team

Table 3 shows the descriptive analysis of the WHOQOL-Bref score according to the assessed domains. It was verified that the highest mean was obtained in the psychological domain (mean = 70.15), followed by social (mean = 70.07) and physical domain (mean = 69.83). The environment domain was the one with the lowest QoL (mean = 63.20).

Table 2 – Distribution of the behavioral, clinical and menstrual habits of the Family Health Team nurses, Recife, Pernambuco, Brazil, 2017 (N=98)

Assessed factor	n	%
Has any chronic illness		
No	47	48.0
Yes	51	52.0
Use of medicine		
No	39	39.8
Yes	59	60.2
Smoker		
No	95	96.9
Yes, up to 10 cigarettes a day	3	3.1
Alcoholic beverage consumption		
No	62	63.3
Yes, once or twice a week	17	17.3
Yes, once or more times in the month	19	19.4
Physical activity		
No	47	48.0
Yes, once or twice a week	24	24.4
Yes, three or more times a week	27	27.6
Menstrual situation		
Yes, without hormone treatment	51	52.0
Yes, with hormonal treatment	7	7.1
No, without hormone treatment	32	32.7
No, with hormonal treatment	8	8.2
Age of last spontaneous menstruation		
35 to 42 years	8	22.9
43 to 47 years	5	14.2
48 to 52 years	12	34.3
53 to 56 years	10	28.6
Type of menopause		
Natural	26	26.5
Unnatural	13	13.3
Has not entered menopause	59	60.2

Note: FHT - Family Health Team.

Table 3 – Descriptive analysis of the WHOQOL-Bref score according to the evaluated domain in the Family Health Team nurses, Recife, Pernambuco, Brazil, 2017

WHOQOL-Bref	Evaluated statistics				
	Minimum	Maximum	Mean	Standard Deviation	CI (95%)
Physical	28.57	100.00	69.83	17.44	66.33 – 73.32
Psychological	20.83	100.00	70.15	14.72	67.20 – 73.11
Social	25.00	100.00	70.07	17.04	66.65 – 73.48
Environment	28.13	100.00	63.20	14.10	60.37 – 66.03
General	25.00	100.00	64.92	19.14	61.09 – 68.76

Table 4 shows that, in relation to the variable "age", the younger age group was associated with a better level of QoL in the four domains, and nurses in the age group between 50 and 59 years had the worst QoL levels, with statistical significance in the psychological (*p* value = 0.025), environment (*p* value = 0.012) and general domains (*p* value = 0.002). On the other hand, the variables "skin color" and "qualification" were not associated, with statistical significance, to the QoL of the nurses. However, people with white skin showed better results in almost all domains, and in general the difference was close to *p* value = 0.05. Regarding the qualification variable, even without statistical significance, nurses with a degree only at

Table 4 – Distribution of socioeconomic and labor variables in relation to the WHOQOL-Bref of the Family Health Team nurses, Recife, Pernambuco, Brazil, 2017

Assessed factor	n	WHOQOL-Bref DOMAINS				
		Physical	Psychological	Social	Environment	General
Age						
40 to 49 years	54	73.1 ± 15.5	73.0 ± 13.5	72.8 ± 14.6	66.0 ± 13.9	67.8 ± 18.1
50 to 59 years	32	63.3 ± 18.9	65.0 ± 15.9	65.6 ± 19.1	58.2 ± 14.0	55.9 ± 20.3
60 years or older	12	72.6 ± 18.1	71.2 ± 13.9	69.4 ± 20.2	64.1 ± 12.6	76.0 ± 8.4
p value	-	0.075[1]	0.025[1]	0.279[1]	0.012[1]	0.002[1]
Skin color						
White	46	72.0 ± 18.0	71.3 ± 15.2	72.3 ± 16.1	65.7 ± 13.3	68.5 ± 19.1
Brown	46	66.9 ± 16.3	68.8 ± 14.4	67.0 ± 17.4	60.9 ± 14.5	62.2 ± 18.4
Black	7	69.4 ± 18.1	69.6 ± 15.2	72.6 ± 20.8	58.5 ± 13.9	55.4 ± 20.2
Others	1	100.0	83.3	83.3	84.4	87.5
p value	-	0.348[1]	0.665[1]	0.245[1]	0.168[1]	0.084[1]
Qualification						
Specialization	83	68.3 ± 18.0	68.9 ± 15.1	69.4 ± 17.3	62.0 ± 14.3	63.4 ± 19.1
Residency	11	76.0 ± 11.7	74.6 ± 12.0	74.2 ± 16.4	69.6 ± 13.3	70.5 ± 17.9
Master's Degree/Doctorate	5	80.7 ± 13.7	81.7 ± 4.8	71.7 ± 16.2	68.1 ± 7.8	77.5 ± 18.5
p value	-	0.153[1]	0.056[1]	0.880[1]	0.184[1]	0.116[1]
Marital status						
Single	19	73.5 ± 16.8	71.1 ± 16.7	71.5 ± 17.4	61.8 ± 16.5	67.8 ± 22.9
Married/stable union	64	69.1 ± 18.0	70.3 ± 14.3	71.6 ± 16.6	63.9 ± 13.8	63.5 ± 18.8
Divorced/widowed	15	68.1 ± 16.2	68.3 ± 14.7	61.7 ± 16.9	62.1 ± 12.9	67.5 ± 15.5
p value	-	0.566[1]	0.755[1]	0.114[1]	0.802[1]	0.480[1]
Family income						
3 to 4 MW	4	66.1 ± 15.0	69.8 ± 7.9	72.9 ± 20.8	59.4 ± 18.2	56.2 ± 16.1
5 to 7 MW	29	68.1 ± 18.5	68.1 ± 16.8	67.8 ± 19.0	60.1 ± 15.5	62.9 ± 22.5
8 to 10 MW	43	69.4 ± 17.8	70.0 ± 14.0	69.0 ± 15.7	62.7 ± 12.7	64.0 ± 18.9
11 MW or more	22	73.5 ± 16.0	73.3 ± 14.4	74.6 ± 16.6	68.9 ± 13.2	71.0 ± 14.1
p value	-	0.653[1]	0.602[1]	0.598[1]	0.164[1]	0.382[1]
Has a child						
No	23	75.6 ± 13.7	75.9 ± 10.8	73.1 ± 12.0	66.3 ± 12.7	67.9 ± 21.6
1 child	25	70.7 ± 17.8	71.2 ± 16.3	68.7 ± 18.8	65.0 ± 14.8	62.0 ± 21.8
2 children	38	65.1 ± 18.9	65.9 ± 15.6	66.4 ± 18.5	60.9 ± 14.7	66.4 ± 17.2
Yes, 3 or more children	12	71.7 ± 16.3	70.5 ± 12.2	78.5 ± 14.0	60.9 ± 13.2	60.4 ± 14.0
p value	-	0.241[1]	0.076[1]	0.090[1]	0.622[1]	0.479[1]
Time of service at the FHT						
≤ 10 years	14	72.7 ± 17.2	72.3 ± 15.9	70.2 ± 20.1	65.0 ± 15.9	62.5 ± 21.9
10 to 20 years	76	69.5 ± 16.1	70.1 ± 13.0	70.0 ± 15.8	62.5 ± 12.7	65.3 ± 18.1
≥ 20 years	8	67.4 ± 29.5	66.7 ± 26.4	70.8 ± 24.8	66.4 ± 23.4	65.6 ± 25.7
p value	-	0.732[2]	0.830[2]	0.860[2]	0.759[2]	0.934[2]
Further employment relationships						
No	38	70.5 ± 18.5	72.7 ± 13.1	70.2 ± 19.1	66.1 ± 14.2	66.8 ± 17.0
Yes	60	69.4 ± 16.9	68.5 ± 15.5	70.0 ± 15.7	61.4 ± 13.8	63.8 ± 20.4
p value	-	0.844[1]	0.209[1]	0.923[1]	0.084[1]	0.638[1]
Weekly workload						
40 hours	40	71.3 ± 18.5	72.2 ± 15.1	71.7 ± 17.8	65.6 ± 13.8	67.2 ± 17.8
41 to 60 hours	15	70.2 ± 15.2	73.3 ± 13.9	65.6 ± 19.4	62.3 ± 16.0	61.7 ± 18.6
≥ 60 hours	43	68.3 ± 17.4	67.2 ± 14.4	70.2 ± 15.6	61.3 ± 13.7	64.0 ± 20.6
p value	-	0.819[2]	0.125[2]	0.379[2]	0.217[2]	0.726[2]

Note: [1] p value of the Mann-Whitney test; [2] p value of the Kruskal-Wallis test; MW – Minimum wage; FHT - Family Health Team.

the specialization level had the worst QoL levels in all domains and also in general. It was verified that there was no statistically significant association between the variables "marital status", "family income" and "number of children" with the QoL of the evaluated nurses. However, it can be noted that the nurses who had the worst level of QoL were divorced or widowed women with lower family income. It is observed that, although there is no statistically significant association with the variables "time of service in the FHT", "further employment relationships" and "weekly workload", in none of the domains evaluated, nurses with a worse level of QoL were professionals with more than one person dependent on income, with children, with another employment relationship and with a weekly workload of more than 40 hours.

Table 5 shows that the variable "has a chronic disease" was negatively associated with the QoL of the evaluated nurses in all domains, and, in general, the p-value was less than 0.05. The continuous use of medications also showed a positive association with a worse QoL in all domains; in the physical domain, this association was statistically significant (p-value = 0.029). Smoking and alcohol consumption did not show a statistically significant association with QoL in any of the WHOQOL-Bref domains. However, the nurses who showed a worse level of QoL were professionals who consumed alcoholic beverages weekly. On the other hand, the practice of physical activity showed a positive and statistically significant association with the QoL of the evaluated nurses in all domains. It was also found that nurses who did not menstruate, did not undergo hormonal treatment and with menopause between the ages of 43 and 47 showed a worse level of QoL. Similarly, natural menopause was associated with poorer QoL in all WHOQOL-Bref domains.

Table 5 – Distribution of clinical and behavioral variables in relation to the WHOQOL-Bref of the Family Health Team nurses, Recife, Pernambuco, Brazil, 2017

Assessed factor	n	WHOQOL-BREF DOMAINS				
		Physical	Psychological	Social	Environment	General
Has a chronic disease						
No	47	72.2 ± 17.0	70.6 ± 15.8	70.4 ± 19.1	64.6 ± 15.8	68.9 ± 15.8
Yes	51	67.6 ± 17.8	69.8 ± 13.8	69.8 ± 15.1	61.9 ± 12.4	61.3 ± 21.3
p value	-	0.181[1]	0.671[1]	0.812[1]	0.406[1]	0.047[1]
Use of medicine						
No	39	74.2 ± 16.6	72.4 ± 15.2	71.8 ± 19.6	65.4 ± 15.8	68.6 ± 17.4
Yes	59	66.9 ± 17.5	68.6 ± 14.3	68.9 ± 15.1	61.8 ± 12.8	62.5 ± 20.0
p value	-	0.029[1]	0.192[1]	0.318[1]	0.196[1]	0.095[1]
Smoker						
No	95	69.8 ± 17.3	70.1 ± 14.8	70.1 ± 17.1	63.3 ± 13.8	64.9 ± 19.2
Yes, up to 10 cigarettes a day	3	71.4 ± 27.0	70.8 ± 12.5	69.4 ± 17.3	60.4 ± 25.1	66.7 ± 19.1
p value	-	0.992[1]	0.983[1]	0.933[1]	0.901[1]	0.975[1]
Intake of alcoholic beverage						
No	62	70.7 ± 17.7	71.4 ± 14.3	71.5 ± 17.6	63.8 ± 14.9	65.9 ± 19.1
Yes, once or twice a week	17	65.1 ± 17.5	65.7 ± 18.0	65.2 ± 16.7	60.3 ± 14.0	58.8 ± 18.1
Yes, one or more times in the month	19	71.2 ± 16.7	70.0 ± 12.9	69.7 ± 15.5	63.8 ± 11.6	67.1 ± 20.1
p value	-	0.522[2]	0.758[2]	0.506[2]	0.809[2]	0.371[2]
Physical activity						
No	47	63.1 ± 17.6	63.9 ± 14.5	65.4 ± 16.4	58.6 ± 13.1	59.3 ± 18.7
Yes, 1 or 2 times a week	24	72.6 ± 16.0	72.9 ± 14.3	74.7 ± 19.1	63.8 ± 13.5	65.6 ± 16.2
Yes, three or more times a week	27	79.1 ± 13.4	78.5 ± 10.3	74.1 ± 14.5	70.7 ± 13.3	74.1 ± 19.3
p value	-	0.001[2]	**<0.001[2]**	0.024[2]	0.004[2]	0.004[2]
Menstrual situation						
Yes, without hormone treatment	51	70.7 ± 17.0	71.7 ± 14.7	72.2 ± 17.3	64.2 ± 14.6	65.9 ± 19.7
Yes, with hormonal treatment	7	71.4 ± 18.0	73.2 ± 12.2	64.3 ± 17.2	69.2 ± 6.1	66.1 ± 9.4
No, without hormone treatment	32	66.9 ± 17.5	66.8 ± 14.6	66.9 ± 15.8	59.6 ± 12.1	63.7 ± 18.6
No, with hormonal treatment	8	75.0 ± 20.7	70.8 ± 17.5	74.0 ± 20.1	66.4 ± 21.0	62.5 ± 25.9
p value	-	0.802[2]	0.598[2]	0.523[2]	0.151[2]	0.993[2]
Age of last spontaneous menstruation						
35 to 42 years	8	67.4 ± 19.3	71.4 ± 10.3	66.7 ± 17.3	62.9 ± 12.6	65.6 ± 19.8
43 to 47 years	5	62.9 ± 23.9	60.0 ± 23.7	68.3 ± 24.6	54.4 ± 22.6	62.5 ± 21.7
48 to 52 years	12	66.4 ± 14.8	63.9 ± 12.6	63.2 ± 14.4	55.5 ± 9.8	62.5 ± 20.6
53 to 56 years	10	70.0 ± 21.3	70.8 ± 18.1	73.3 ± 18.8	65.6 ± 16.1	62.5 ± 22.0
p value	-	0.917[2]	0.525[2]	0.504[2]	0.343[2]	0.969[2]
Type of menopause						
Natural	26	66.9 ± 17.8	64.3 ± 16.5	67.3 ± 18.1	58.5 ± 14.7	62.5 ± 22.1
Unnatural	13	72.3 ± 19.7	74.7 ± 9.5	69.9 ± 14.6	65.6 ± 13.3	67.3 ± 14.0
Have not had menopause yet	59	70.6 ± 16.9	71.8 ± 14.2	71.3 ± 17.2	64.7 ± 13.8	65.5 ± 18.9
p value	-	0.630[2]	0.052[2]	0.684[2]	0.053[2]	0.937[2]

Note: [1] p value of the Mann-Whitney test; [2] p value of the Kruskal-Wallis test.

DISCUSSION

A possible interpretation for the finding that younger nurses (40 to 49 years) were the ones with the best QoL (psychological, environmental and general domains) is that, in this population, the process of ovarian failure is beginning, estrogen levels are still not very low, which would explain a lower symptomatology in relation to the other age groups (mainly the range of 50 to 59 years), as well as more frequent physical activity, which, as it is known, has a positive impact on the QoL.

Regarding skin color, in spite of the absence of statistical significance, nonwhite (brown and black) showed a worse QoL in all domains. This finding is in line with the Annual Report on Racial Inequalities in Brazil, which indicates worse afrodescendent conditions in any evaluated variable[13]. However, a cross-sectional study with 626 women in the climacteric, aged 45-54 years, living in the city of Baltimore, USA, did not identify an association between race and QoL levels[14].

Regarding the variable "qualification", the findings indicate that nurses who only had a diploma of specialists showed worse QoL in all WHOQOL-Bref domains. One possible explanation for these results is that, with increased qualifications, the professional manages to improve their career plan and acquire salary bonuses that can help to contemplate their socioeconomic needs. In addition, the completion of a residency and stricto sensu post-graduation increases the possibility of qualification and knowledge about caring, allowing not only better care but also self-knowledge.

Regarding the civil status of the studied nurses, the findings, although not statistically significant, showed that those who declared themselves divorced/widowed had a worse QoL in the physical, psychological, social and environmental domains than those who had a partner. A study conducted by Almeida et al. with 330 women in the climacteric phase using the FHT of the city of Cajazeiras, PB, in which 73% of them had an active sexual life, indicated that the presence of a partner in their lives, especially in the climacteric, can benefit them through a feeling of protection and emotional stability[15].

Analyzing the impact of family income, an interesting finding was observed, although not statistically significant. There was an association between the variable "income" and the QoL of these nurses, since those who declared lower income (below 11 minimum

wages) showed worse QoL in all domains and also in general, reinforcing the view that earnings constitute an important factor related to quality of life. Schrader et al., in a qualitative study, evaluated the quality of working life (QWL) of nurses at primary healthcare units of Pelotas, RS, and found dissatisfaction among these professionals with the received salaries[16].

Nurses who had chronic diseases and who used continuous medication had worse QoL in all WHOQOL-Bref domains. Which, in addition to framing a logical relation between QoL and illnesses, may suggest that the arduous routine of healthcare professionals, in addition to requiring a lot of energy and dedication, overwhelms and stresses them. This leads them to leave their self-care aside and to make negative changes in their life habits, contributing to the onset of chronic diseases that, in turn, lead to drug treatments. These findings are similar to those of Serpa et al., who investigated factors associated with quality of life in 113 climacteric women living in the city of Ouro Preto, MG, whose results showed that the presence of chronic disease and the use of medications were associated with a worse QoL[17].

When analyzing the characteristics related to life habits (physical activity practice, smoking habits and alcohol consumption), a positive and statistically significant association was observed between the QoL of the nurses and physical exercises. The study by Barreto et al., who evaluated the quality of life in two groups of 30 women, one of them with physical activity practitioners and the other with non-practitioners, aged between 40 and 60 years, showed that the practitioners had lower climacteric symptomatology and were healthier than non-practitioners. As physical exercise improves body conditioning and various aspects of people's health, they start to report better satisfaction with their quality of life[18].

As for alcohol consumption, no statistically significant results were found for the QoL of the studied nurses, but those who consumed alcohol once or more times per week had a worse QoL level. These findings may be explained by a study performed with climacteric women between the ages of 40 and 65, which identified that alcohol consumption was associated with an increase in the intensity of heat flushes, contributing to a worse QoL[3].

Surprisingly, no clear relation was found between smoking and worse QoL, perhaps because of the low number of smokers in our study. However, it is worth emphasizing that Azevedo et al., when analyzing the association between occupational stress, quality of life at work and smoking in 309 nursing professionals at the Prado Valadares General Hospital, in the municipality of Jequié, BA, found a positive relation between dissatisfaction with quality of working life and smoking[19].

Analyzing the menstrual characteristics, it was observed that nurses who did not menstruate and did no type of hormonal treatment for the climacteric had worse QoL in the physical, psychic and environmental domains of the WHOQOL-Bref. These results may also be explained by the decline of estrogen after menopause, which would lead to a greater intensity of climacteric symptoms that, without the help of hormone replacement or specific treatments, may be more severe and worsen the QoL of these women. These findings corroborate those of Freitas and Barbosa, who, when analyzing the QoL and the psychological well-being of 59 women aged 49 to 63 years treated in a climacteric outpatient clinic of a university hospital, found a better QoL, with statistical significance, among women who underwent hormone replacement therapy[20].

An interesting data that is difficult to interpret relates to the type of menopause. The natural one was associated with a worse QoL in all WHOQOL-Bref domains, differently from the findings by Gallon and Wender, who did not observe influence of menopause in the QoL of 200 climacteric women aged between 40-65 years. However, these authors found that those who were still menstruating showed better QoL in the urogenital domain[21]. Ribeiro et al., when evaluating the climacteric symptoms and their influence on the QoL of 80 women between the ages of 40 and 65 belonging to the health units of the city of Alfenas, MG, also did not observe a relation between the phases of menopause (peri or post), severity of climacteric symptoms and impairment of quality of life domains[8].

The age at which the menopause occurred did not statistically interfere with the QoL of the nurses. However, it is worth mentioning those who had their last menstrual episode in the age range between 43 and 47 years, because they had a worse QoL in the physical, psychic and environmental domains of the WHOQOL-Bref, reinforcing the view that an earlier loss of "estrogen protection" may have a negative impact on women's lives.

With regard to QoL in relation to work activities, the results of this research, in terms of length of service in the FHT unit, do not allow a clear interpretation. However, the findings of Fonseca et al. indicate the need for a greater reflection, since these authors, when analyzing the QoL of nine climacteric nursing professionals working in a university hospital in Rio de Janeiro, RJ, showed in the statements of their interviewees, physical and psychological exhaustion after years in the profession[22]. Perhaps the physical and emotional exhaustion of the nursing profession is cumulative and, when coupled with the climacteric symptoms, might negatively impact — and in a more intense way — the climacteric professionals who, possibly, are the ones with the most time in the profession.

The presence of another employment relationship is worth noting, despite its non-statistical significance, since nurses who reported having more than one job showed worse QoL in all WHOQOL-Bref domains. In addition, working over 40 hours per week also appears to be an important variable for a worse QoL. These findings, together, reinforce the hypothesis that, in a profession with so much responsibility and stress, the labor question can be impacting on the quality of life of climacteric nurses. However, Marques et al., researching 50 nursing professionals — who were not necessarily in the climacteric — from a rural and urban area of a city in Minas Gerais, showed that most of the investigated nurses had only one employment relationship, with a workload of 40 hours, and they still had low levels of QoL between the work context and the physical, psychological and social domains[23].

Limitations of the study

Although the results of the screen survey reinforce the importance of studying the QoL theme in climacteric nurses working in primary healthcare, it is necessary to highlight the small sample

size and the fact that many of the associations are not statistically significant, in addition the impossibility of generalizing the results for the other regions of the country.

Contributions to the field of nursing, health or public policy

The obtained results may and should be used as subsidies for reflections and planning, within the policy of care to women, aiming at the promotion of strategies to improve the quality of life of the climacteric nurses who work in primary care.

CONCLUSION

The results suggest that several factors interfere in the QoL of female climacteric nurses who work in the FHT, indicating the need for an immediate reflection on the variables studied, including the importance of promoting healthy habits and lifestyles and better working conditions and better remuneration. In addition, further research is needed to assess the physical, emotional, and social health of this important professional segment, particularly in this complex stage of women's lives.

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