European Journal of Epidemiology **15**: 231–236, 1999.

Use of health services by the climacteric women in primary health care: The need for an integral approach

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Accepted in revised form 19 December 1998

Abstract. During the climacteric, women experience multiple health problems. As their needs are not catered for in an integral fashion due to the lack of any specific programme or mechanism to provide for this, they show an increased use of the health services, and an increased rate of referrals to different specialists. This study, carried out in a Basic Health Zone in San Fernando (Cádiz, Andalusía, Spain) on a sample of climacteric women who attended the Health Centre during 1995, examines these points and shows a significantly higher use of the health services in relation to the rest of the female population (those who are not in the climacteric age group) as well as a high percentage of referrals (74.6%) to specialists. It was found that both the level of knowledge about the climacteric and the use of the health services were influenced by the educational level ($p < 0.001$) and age ($p < 0.05$). Women who felt that their families provided an understanding and supportive attitude were found to have less psychological problems and, consequently, less consultations and referrals for this reason ($p < 0.00001$). The authors hope that their findings will provide a basis for the setting up of a programme of integral health care for climacteric women at the level of primary health care. With careful planning and the drawing up of a strategic plan, it would be possible to provide for the needs of this population group in a more satisfactory way, and it would also permit a rationalization of the resources available.

Key words: Climacteric, Health promotion, Level of knowledge, Use of health services

Introduction

Both the directives issued by the Spanish Ministry of Health and Consumption and the Health Plan for Andalusía contemplate the possibility of providing integral and protocolised care for climacteric women at the level of primary health care (Health Plan for Andalusía, 1993).

In reality, however, each symptom is dealt with separately under different subprograms. It is only at the tertiary level in the Spanish Health Services that we find specific menopause units and, due to the high level of specialisation and the difficulty of access, these usually have a low level of catchment (1.5% in Cádiz, Andalusía, Spain in 1995).

The average age for the menopause ('last menstruation, established after a minimum of twelve months amenorrhea and when the possibility of pregnancy has been eliminated') is given by most writers as 50 years with a standard deviation of 1.5 years [1–3]. There is an age range from 40 to 57 years [4].

The climacteric is the variable period of time surrounding the menopause. It can begin as early as eight years before and end up to six years after. It should be stressed that the climacteric is particularly worthy of attention given that more than a third of the total female population will belong to this age group and that it constitutes a considerable period of a woman's life during which she is suffering from the corresponding symptoms and health problems.

During this time women usually experience a number of symptoms and disorders attributable to the decline in the endocrine function of the ovaries. Authors such as Bedoya, Fritz, Jones, and Maher [4–7] speak of 'short term' symptoms (hot flushes, menstrual irregularities, insomnia, anxiety, depression), 'medium term' symptoms, especially genital, sexual (decline of libido, painful sexual intercourse) and urinary tract problems (urinary incontinence and urinary infection among others) and 'long term' symptoms, particularly osteoporosis and cardiovascular disorders, principally ischemic cardiopathy with elevated LDL and, above all, high blood pressure.

This combination of disorders and symptoms is known as 'the climacteric syndrome' [2].

After investigating a group of climacteric women who were patients at a Primary Health Care Centre, the authors have come to the conclusion that a mechanism should be created which would offer specific, integral attention for climacteric women

at the level of Primary Health Care, to provide them with easier access to solutions for their health problems.

The study, which is descriptive, was based on a small area, the Basic Health Zone (BHZ) Rodríguez Arias in San Fernando (Cádiz, Andalusía, Spain) which is fully identifiable from a geographic, demographic and epidemiological point of view, covering a population of 25,000 inhabitants (32% of the population of San Fernando). The demographic characteristics of this Basic Health Zone are representative of other Basic Health Zones, not only in the province of Cádiz, but also Andalusía.

The Health Centre is staffed by general practitioners, pediatricians, nurses, one social worker, one veterinary surgeon and auxiliary staff. The specialist consultants, including gynaecologists are in the main public hospital 'Puerta del Mar', which is 10 km away from the Health Centre, and has a Menopause Unit.

The aims of the study were:

1. To ascertain the average age of the climacteric women in the BHZ studied.
2. To ascertain the degree of use of health services by the women in the BHZ, aged from 40–57 years (climacteric), and the non-climacteric female population (12–39 years and 58 years plus) during 1995.
3. To consider some of the variables which may lead to a greater or lesser use of the health services, such as age and educational level.
4. To determine the principal motives which lead these women to consult their doctor.
5. To determine the degree of referrals of the climacteric women studied to other levels of the health service.
6. To determine the level of knowledge about the climacteric of the climacteric women in the BHZ and the possible relation with their use of the health services, their educational level and their age.
7. To determine how much family support these women receive and to evaluate what influence this factor may have on the appearance of psychological disorders and related medical consultations.

Materials and methods

A descriptive, correlational study was carried out for the women belonging to the Rodríguez Arias Basic Health Zone in San Fernando, Cádiz (Andalusía, Spain) who showed symptoms of the climacteric syndrome, aged between 40 and 57 years, excluding these who had previously undergone an oophorectomy, and who used the health services during the period from 1st January 1995 to 31st of the same year.

The total population of women over 12 years old, belonging to the BHZ under study is 8.316%; 1.764% climacteric women and 6.552% non-climacteric women (12–39 years or 58 years plus). Although the group of non-climateric women cover a wide age range, adolescents and women over 70 years represent a low percentage of the population corresponding to the Rodríguez Arias Health Centre and their consultations were minimal (the former because of their generally good state of health and the latter because they have a higher percentage of home visits). For this reason possible distortion of the results due to the wide age range is minimal. The vast majority of the women who consulted their doctor at the Health Centre were between 30 and 65 years of age.

From the appointment records of the Rodríguez Arias Health Centre for 1995, information was obtained corresponding to the women in each group who had used the health services, that is, they had consulted their family doctor in the Health Centre. This was the reference population for the study from which the sample was taken.

The calculation of the size of the sample was computer aided (Epi-Info 5.0) using this group of women for an expected frequency of 50% and a confidence interval of 95%. There were found to be 291 climacteric women and 347 non-climacteric women.

Subsequently, sample women were selected at random from the appointment records for each of the groups to be studied (Figure 1).

A form was drawn up to include: personal information (age and educational level, among oth-

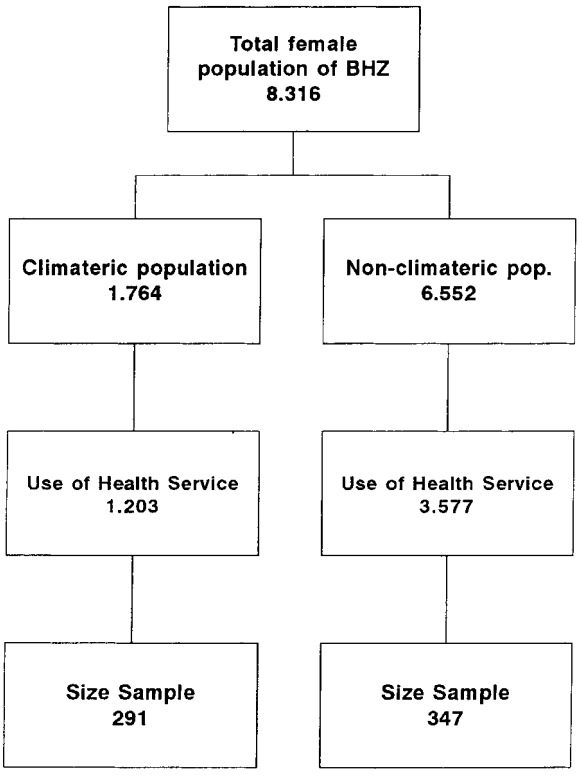

Figure 1. Population in the study.

ers), reasons for consultation, referrals and reasons for the same, excluding the usual screening for the age group. This data was obtained from the monitoring sheets in the clinical histories of the women to be studied.

The information referring to the non-climacteric sample of the population, which was taken from the appointment records of the Health Centre for 1995, was limited by the number of consultations made for that year.

A questionnaire was also drawn up comprising a series of questions to ascertain the level of knowledge of the women in the sample about the climacteric, including: the age at which the climacteric usually begins, accompanying symptoms and their identification, the existence of treatment and if they had requested it.

In anticipation of the possible answers to these questions, three levels were established to reflect the level of knowledge:
– low: 0–3 correct answers.
– medium: 4–7 correct answers.
– high: 8–11 correct answers.
The questionnaire also covered information about the climacteric that the women had received from their doctors, and if they felt that their family were supportive and understanding.

Once the questionnaire had been drawn up it was validated and no corrections were found to be necessary. The questionnaire was applied to the 291 selected climacteric women during home visits by 4 doctors and one nurse, having previously agreed on the criteria and procedure to be followed.

The information obtained was processed with the aid of a computer (Epi-Info 5.0).

For the comparison of the proportions, the χ^2 test with the correction of Yates was used to obtain a confidence interval of 99%. Anova and Bartlett's test of homogeneity and variance were also applied for the comparison of averages when they were considered necessary.

Results

The total population of climacteric women belonging to the Health Centre who consulted their doctor in 1995 on at least one occasion was 1203 (68%), generating 13,582 visits, whereas the number of women of the non-climacteric population over 12 years old who made consultations was 3577 (55%), generating a total of 27,847 visits in the same period. This gives an average use of the health services of 11.29 visits per year for the climacteric women as against 7.8 visits per year for the non-climacteric women.

From the sample selected from the population of climacteric women who used the health services in 1995, the following results were obtained:

The average age of the climacteric women was 49.5 years with a standard deviation of 1.5 years.

Regarding the educational level of the women, 27.9% (79 women) had no schooling, 40.7% (115 women) had primary education, 21.9% (62 women) had secondary education and 9.6% (27 women) had received further and/or university education.

An Anova test, to compare the average use of the health services with the educational level of the women showed that those with a higher educational level used the health services less versus no-schooling, primary-education and secondary-education women ($p < 0.01$).

Bartlett's homogeneity of the variance showed that the average use of the health services varied significantly according to the age of the woman, and that younger women used the health services less ($p < 0.01$).

The principal motives for consultation with the family doctor are shown in Table 1, where we can see that rheumatic symptoms (pains in the joints) were the prime reason for 591 visits (18.5%), followed by cardiovascular pathology (principally high blood pressure and alterations in the heart beat) with 447 visits (14%), genital or sexual complaints (already detailed in the introduction) caused 362 visits (11.3%), psychological symptoms (anxiety, depression) 359 visits (11.3%), hot flushes 346 visits (10.8%), disorders of the metabolism 342 visits (10.7%), urinary infections 283 visits (8.9%) and other motives which do not come into the previous categories with a total of 188 visits (5.9%). In 8.3% of the total number of visits the motive for the consultation does not figure in the patient's clinical record.

74.6% of the climacteric women were referred to a specialist at some time, with an average of 1.78 referrals per woman and year. Routine screening in this age group, such as cervical smears or mammographies were not included.

Of the total number of referrals, the highest percentage were due to rheumatic causes which came to 28,125, followed by genital complaints 23%, metabolism disorders 14.3%, cardiovascular problems 14.1%, psychological complaints 12.5%, urinary infections 7.1% and other reasons 1%.

Table 1. Reasons for consultation with a family doctor by the climacteric women (n = 291)

Symptoms	N	%
Rheumatic	591	18.5
Cardiovascular	447	14.0
Genital or sexual	362	11.3
Psychological	359	11.3
Hot flushes	346	10.8
Disorders of metabolism	342	10.7
Urinary tract infections	283	8.9
Other motives	188	5.9

These percentages can be misleading, because when we calculate the rate of referrals according to symptoms (the frequency of referral for each reason for every 100 consultations for the same reason) as is shown in Table 2, we find that the consultations made for genital and/or sexual problems lead to the highest number of referrals, 32%, followed by rheumatic symptoms 24%, metabolism disorders 21.1% and psychological problems 17.6%.

Overall, as was previously mentioned, three levels were established to reflect the women's level of knowledge about the climacteric, according to their answers to the questions shown in Figure 2. 42.8% of the women were found to have a high level of knowledge, 40.6% a medium level and 16.6% a low level.

One of the questions which figured in the questionnaire to ascertain the level of knowledge was to determine if the climacteric women knew of the existence of hormone replacement therapy (HRT). 61% claimed to know of it but only 30% of the women questioned had requested the treatment.

No statistically significant difference was found to relate the level of the women's knowledge about the climacteric and the degree of use of the health services.

On the other hand there was an appreciably significant statistical difference in the age and educational level of the women related to their knowledge about the climacteric: the higher the educational level and the younger the woman ($p < 0.05$), the higher the level of knowledge was about the climacteric ($p < 0.001$).

Finally, it was observed that 65.7% of the women felt that their families were supportive and when they were supported they showed less psychological problems and, consequently, the less they consulted their doctor for this reason ($p < 0.00001$).

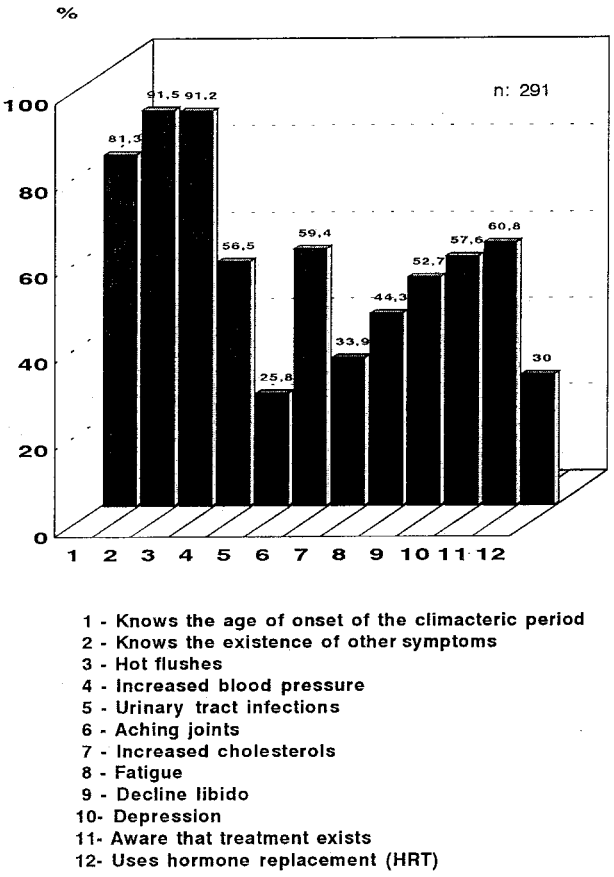

Figure 2. Symptoms and knowledge about the climacteric syndrome among climacteric women in the population sample.

Discussion

The average age of the women in the climacteric phase obtained at the Basic Health Zone studied is similar to that described by the majority of authors, who find that it occurs at fifty years of age, with a standard deviation of 1.5 years [1]. This is slightly higher than that found by Mayer and Linscott [8], Hughes [9], Comino [2] and the Spanish Society of Gynaecology and Obstetrics, which varies from 48.6 to 47 years in the last case [4].

Although the great use of the health services on the part of this group of women has been pointed out by authors such as Barlow and Borrell [10, 11] this has not been correlated with the use of services by the remaining groups of women.

The principal motives for which the climacteric women in our Basic Health Zone consulted the doctor were comparable with the findings of Barlow [10] and Jiménez de Luque [12] among others, the most frequent reasons were symptoms associated with rheumatic, cardiovascular, genital and sexual problems. It has not been our concern in this study, as has been the case with some other authors [13] to consider the difference in symptoms according to whether or not HRT was used.

The malaise felt by these women, due to their multiple symptoms, and due to the fact these symptoms were not treated as a whole, meant they were referred to a number of different specialists, which further increased their feeling of malaise.

This situation is not to be found to the same degree in all climacteric women. Variables such as age or

Table 2. Referrals

Cause	%	Rate[a]
Rheumatic	28.1	24.0
Genital or sexual	23.0	32.0
Disorders of metabolism	14.3	21.0
Cardiovascular	14.1	15.3
Psycological	12.5	17.6
Urinary tract infections	7.1	12.7
Other motives	1.0	2.7

[a] Frequency of referral for each reason for every 100 consultations for the same reason.

educational level have a significant influence on the magnitude of the problem; following this line, we have found no studies which consider the possible relation between these variables and the use of the health services.

There was a strikingly high percentage of women who had no schooling (285) and of women with only primary education (41%). This is in fact typical for middle-aged women in most rural areas in Spain, due to the economic depression after the Spanish civil war heat did not encourage women's education. The situation is very different today thanks to compulsory education and a change of mentality in relation to women.

The results obtained for the symptoms identified with the climacteric period by the women in our sample were observed to be similar to those of Mayer and Linscott [8], Randall [14] and Barlow [10] who found hot flushes and aching joints as the most frequently symptoms identified by the climacteric women.

Tropeano et al. [15] and Tejerizo [16] give particular importance to the fact that the women who felt that their families gave them support and understanding appeared to have less problems of a psychological nature and ask for less help for these motives. This is in consistence with the results obtained in our study.

Conclusions

1. The use of the health services by the climacteric women of the Rodriguez Arias Basic Health Zone in San Fernando (Cádiz) during 1995 was significantly superior to that of non-climacteric women for the same period of time.
2. The principal motives for consultation were rheumatic, followed by cardiovascular and genital and/or sexual problems.
3. There is a statistically significant relation between the use of the health services by climacteric women and their educational level and age.
4. There is a high degree of referral to second or third degree health care for the climacteric women who used the health services.
5. The climacteric women in the Rodriguez Arias Health Zone in San Fernando (Cádiz) have a medium–high level of knowledge about the climacteric process. Younger women, with a higher educational level, have more knowledge about the climacteric syndrome.
6. Climacteric women who felt that their families were supportive and understanding used the health services less for psychological reasons.
7. The present high degree of referrals and high level of use of the health services could be brought under control and, consequently, resources could be rationalized, if a programme of integral Health Care for climacteric women were established at the level of Primary Health Care. This is a possibility which is included in the Spanish legislation, through the Goverment Health Programme for the Autonomy of Andalusia, but which has not as yet been put into practice. However, in view of daily experience, the results of this study and the recommendations of a number of different authors [17–20], the present authors feel that a plan of action should be designed with three main aims:

To create a mechanism which provides for the health care of the climacteric woman in the Basic Health Zone (BHZ) within the Health Centre: A Primary Health Care Menopause Unit (PHCMU). This unit would be made up of a multidisciplinary team consisting of a family doctor, nurses, a social worker and psychologist.

To give counselling in the family environment of the climacteric woman of the BHZ under the care of the Unit, in those cases where it is considered to be prejudicial to the psychological welfare of the woman.

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