Proceedings of the Estonian Academy of Sciences
2025, **74**, 3, 461–472

https://doi.org/10.3176/proc.2025.3.16

www.eap.ee/proceedings
Estonian Academy Publishers

PRIMARY NURSING CARE

RESEARCH ARTICLE

Received 17 December 2024
Accepted 29 April 2025
Available online 21 August 2025

Keywords:
climacteric, nursing, perimenopause, menopause, woman's health, nursing counselling

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Citation:
Grünthal-Drell, M. 2025. The experiences and needs of family nurses in counselling climacteric female patients. *Proceedings of the Estonian Academy of Sciences*, **74**(3), 461–472.
https://doi.org/10.3176/proc.2025.3.16

The experiences and needs of family nurses in counselling climacteric female patients

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ABSTRACT

Primary health care is the first level of health care where many women with climacteric symptoms seek help, and nurses should be equipped with the knowledge and skills to care for and guide women through this critical life transition. The aim of the study was to gain an overview of nurses' experiences and needs in counselling climacteric women in daily nursing practice. A qualitative study was conducted using semi-structured interviews. Family nurses observed that patients came to appointments with multiple health problems that they did not normally associate with the climacteric period. Nurses felt uncertain and found counselling middle-aged women challenging. They promoted a healthy lifestyle with physical activity to normalise body weight, prevent osteoporosis, and maintain musculoskeletal function. They also advocated needs-based nutrition to improve the quality of life of middle-aged women, reduce anxiety and heart palpitations, and achieve hormonal balance. All nurses emphasised the need to improve their knowledge of collecting medical history to identify menopausal symptoms; some nurses expressed their desire for training in motivational communication and counselling techniques, but relevant opportunities for nurses were lacking. Several needs were mentioned, including yoga exercises and other tools to help to alleviate patients' sleep or mood problems, financial compensation, informational leaflets, and a single website dedicated to women's health and well-being as a useful tool for both health professionals and patients.

1. Introduction

Nurses are a crucially important part of the primary care workforce (Peacock et.al 2023; Hutchison 2024). They are well situated to help and advise women through the climacteric period (Stevenson 2016). Nurses engage in supportive, educational, and problem management counselling (Weaver 2002), which involves a two-way communication to interpret assessment results and identify the patient's problems, needs, and goals (Vasiloglou et al. 2019). Thus, a nurse should be able to create a space where menopausal women can freely express their feelings, while also offering the necessary emotional support and information about the changes occurring in their bodies. This will help to prevent possible negative effects on their health (Curta and Weissheimer 2020).

The term 'menopause' is much more frequently used than 'climacteric'; however, we should consider that 'menopause' refers to a specific event, the cessation of menses. 'Climacteric' refers to gradual changes of ovarian function that start before the menopause and continue thereafter for a while (Blümel et. al 2013). According to Cleveland Clinic (n.d.), the menopause is defined as the final menstruation in a woman's life, with no menstruation following within one year. By 2030, it is estimated that over one billion women across the globe will be perimenopausal or postmenopausal, and nearly 50 million women will be expected to reach the menopause each year (Namazi et al. 2019; Aljumah et al. 2023). Thus, the global population of postmenopausal women is growing. In 2021, women aged 50 and over accounted for 26% of all women and girls globally (WHO 2024). Women may have mixed responses regarding their attitudes towards the menopause, ranging from perceiving the menopause as a normal life phase to viewing it as a transition with different problems. Women may have positive feelings in the form of relief from pain or the burden of menstruation management. Alternatively, they may have negative attitudes related to concerns or personal experiences of mental instability, signs of ageing, and loss of fertility (Aljumah et al. 2023).

Globally, women at every stage of life have little counselling information about the menopause, and the media often presents it negatively (Harper et al. 2022).

As the perimenopause is often noted as a hidden phenomenon (Richardson et al. 2023), women are unaware that the symptoms they experience may be related to the perimenopause and can manifest in biological, psychological, or social contexts (Harper et al. 2022). Women (65%–77%) feel unprepared when it comes to the climacteric period of their lives and report that they lack important knowledge about what to expect and how to optimise their health (Marlatt et al. 2018; Lillis et al. 2021). Women may experience body changes such as vasomotor symptoms (hot flushes and night sweats, fluctuating blood pressure), heart palpitations, bladder problems, general malaise, fatigue, sleep difficulties, changes in the body weight and mood, and aching muscles or joints (Hoga et al. 2015; Hickey et al. 2022). Climacteric women quite often experience urination problems and vaginal dryness caused by a thinned mucous membrane (Holloway 2017).

Therefore, perimenopausal care plays an important role in the promotion of healthy ageing and quality of life (WHO 2024). Nurses who support midlife patients need to know that the menopause can begin while periods are still regular, that there is a variety of symptoms, and that there are interaction strategies that might lead to more satisfied patients (Richardson et al. 2023). Also, nurses should take the perimenopausal context into account during all consultations with women in this life stage, even when the consultation is for conditions such as hypertension, diabetes mellitus, or chronic pain (Curta and Weissheimer 2020). Women who are awaiting or have undergone gynaecological surgery also need advice from the nurse (Holloway 2017), as the menopause can be induced by surgical procedures that involve the removal of both ovaries or medical interventions that cause the cessation of ovarian function (for example, radiation therapy or chemotherapy) (WHO 2024). Therefore, meno- and postmenopausal health management is an important topic in all fields of health care, not solely in gynaecology (Calow et al. 2023).

While the majority of women experience body changes over the menopausal transition, most consider this a natural process that is manageable without medical intervention. Many women prefer to manage their symptoms this way, if possible (Hickey et al. 2022), therefore this study focused more on non-pharmacological approaches to relieving menopausal symptoms. It is important that women's attention is drawn to a healthy lifestyle to encourage positive health-related behaviours, including dietary changes, proper nutrition, physical activity, and the elimination of harmful habits such as smoking or alcohol consumption (Ko and Park 2021). Precise definition in a nursing diagnosis is important to ensure the quality of the nursing plan for women by helping to alleviate any symptoms that accompany the menopause (Ohara et al 2023). It is a fundamental necessity in nursing to recommend physical activity to women, which can improve their well-being, alleviate the symptoms, reduce the risk of chronic diseases, and improve their quality of life (Curta and Weissheimer 2020). According to Peacock et al. (2023), it is also very important that nurses introduce other methods to allow stress alleviation. A range of non-pharmaceutical approaches are effective for vasomotor symptoms. For example, cognitive behaviour therapy can help by reducing stress, challenging overly negative beliefs about the menopause, and improving reactions to vasomotor symptoms, which in turn facilitates coping (Hunter 2020).

Women should always be provided with research-based information about the climacteric period (Peacock et al. 2023). The European Menopause Survey showed that women obtained information mainly from non-medical sources such as magazines and television, which may not always reflect the correct information (Aljumah et al. 2023). Balanced, evidence-based information about the normal changes to expect during the menopausal transition and beyond can help women to prepare, empower them to manage the menopause, and give them confidence in navigating this life stage (Hickey et al. 2022). Professional information helps women to have an accurate perception of themselves and the situation by clarifying misinformation or misunderstandings (Weaver 2002).

1.1. Problem formulation

Social, psychological, and physical health support during the menopausal transition and after the menopause should be an integral part of health care (WHO 2024). Primary health care is the first level of health care where many women with menopausal symptoms seek help (Peacock et.al 2023). Women should be provided with the information, appropriate assessment, alleviating methods, and treatments that will improve their quality of life and aid in health promotion throughout the climacteric period (Holloway 2017; Harper et al. 2022; Aljumah et al. 2023; Calow et al. 2023). Women wish to be heard and better supported by their healthcare providers (Richardson et al. 2023); however, they receive little or no information about the menopause from their healthcare professionals (Hoga et al. 2015; Alspaugh et al. 2020). Women's lack of education (Marlatt et al. 2018; Lillis et al. 2021; Harper et al. 2022; Aljumah et al. 2023) and their healthcare professionals' lack of adequate training on the menopause means that women enter this critical life stage uneducated and unsupported (Harper et al. 2022; Aljumah et al. 2023; WHO 2024). The menopause currently receives limited attention in the training curricula for many healthcare workers, and there is a need to increase understanding of the menopause by promoting the inclusion of training on the menopause and treatment options in pre-service curricula for health workers (WHO 2024). It is vital that everyone is taught about the menopause and that healthcare professionals receive comprehensive education. Nurses should be equipped with the knowledge and skills to help to guide and advise women through this critical life transition (Holloway 2017; Aljumah et al. 2023; Calow et al. 2023).

1.2. Problem solution

The task of nursing education is to prepare healthcare specialists to cope with the challenges associated with nursing work, and nurses' knowledge and skills should be able to promote and maintain health at the primary level for people of all ages (Tallinna Tervishoiu Kõrgkool 2023; Teal et al. 2024). The menopause represents a significant stage of life and merits inclusion within nursing education in a meaningful way. It is

therefore essential that the subject is covered in nursing curricula (Calow et al. 2023). Before starting to review or make changes to the nursing curriculum from a theoretical point of view, it is important to identify what practices characterise the work of nurses in real life regarding the current topic. The aim of the study was to gain an overview of nurses' experiences and needs in counselling climacteric women in daily nursing practice. Based on the research problem and the aim of this study, the following two research tasks were formulated: 1) describe the experiences of family nurses in counselling climacteric female patients and 2) describe the needs of family nurses in counselling climacteric female patients. Understanding nurses' experiences and needs in counselling climacteric women will help to make the necessary adjustments in nursing education. Strengthening nursing education will increase patient-centredness in primary health care and improve knowledge and care for midlife women.

2. Materials and methods

2.1. Methodological approaches

The qualitative method was used to find the required answers to the research tasks. The starting point for a qualitative and phenomenological study is describing real life as well as the meaning ascribed to it (Creswell 2013). The nurses developed subjective meanings of their experiences in the current study. According to Creswell (2009), meanings directed toward certain objects or things are used by the the researcher to create a detailed and rich description of a central phenomenon. As the researcher's aim is to understand the essence of participants' experiences, these studies may not follow a specific theoretical framework (Riemen 1986; Creswell 2009). In the current study, the data were collected through semi-structured interviews, which were conducted in person. This data collection instrument is the most widely used interviewing format for qualitative research. It is also widely used by healthcare researchers to co-create meaning with interviewees by reconstructing perceptions of events and experiences related to health and health care delivery (DiCicco-Bloom and Crabtree 2006). Knowledge gained from qualitative research methods provides information for the healthcare field to contribute to the development of the field and raise awareness about participant's experiences. Personal experiences in the healthcare field cannot always be measured or counted, and samples are usually small (Hammarberg et al. 2016).

2.2. The sample

The subjects of this research were nurses working in a health centre that has a modern working environment and the largest number of nurses in Western Estonia. A purposive sample was used in the current study. The researcher's aim was to select representatives and/or ideal interviewees, depending on the purpose of the study (Rämmer 2014). Inclusion criteria for the study participants consisted of the following: 1) the participant had a nursing diploma, 2) the participant worked as a family nurse in the health centre, and 3) the participant voluntarily agreed to participate in the study. Contact details of the subjects were forwarded to the author by the representative of the health centre, a member of the board of the Estonian Union of Family Nurses, who was also employed there. Eleven nurses were initially contacted by email and nine of them responded. Invitations were sent to the nurses prior to the interview, including the title of the study, a description of its aim and methodology, and information about the importance of nurses working with women in the climacteric period. All volunteers were contacted separately, and the date of the interview was agreed on individually. Scheduling was done by email, taking into account the nurses' wish to conduct interviews during their working hours. The *Information sheet and informed consent form* were signed digitally before the interviews, which confirmed the nurses' agreement to participate in the study voluntarily and the anonymity of their data. A total of nine nurses participated in the study.

2.3. Data collection

Data were collected through semi-structured, in-person interviews conducted in March 2023 using open-ended questions that encouraged the interviewees to provide more substantial answers. This method made it possible to understand and interpret the experiences and views of the nurses who were being interviewed (Magnusson and Marecek 2015). The semi-structured interview plan was developed in previous studies (Brown et al. 2006; Walseth et al. 2011; Erci et al. 2013) and included ten questions, from which eight questions were open-ended. The more open-ended the questioning, the better, as it allows the interviewees to answer the way they prefer while the researcher listens carefully to what they say or do in their real-life settings (Creswell 2009). The interview included an introductory part with two questions regarding the subject. Two main topics with eight questions followed the introductory part. The first main topic in the interview included four research questions about the interviewee's experiences of counselling climacteric patients in a health centre. The second main topic with four research questions looked for answers to the interviewee's needs in counselling climacteric patients in a health centre. The summary part was for the interviewee to add any information they considered necessary. This study did not focus on medication recommendations for climacteric women, and the questions did not include them. Only non-pharmacological methods for alleviating women's menopausal symptoms that nurses themselves could recommend to patients in the health centre were discussed.

Nine nurses as study participants were visited at the health centre. According to DiCicco-Bloom and Crabtree (2006), interviews in person were based on a previously agreed schedule at a designated time and in an office that imitated the natural working environment, outside of everyday events. As suggested by McGrath et al. (2018), the interviews were conducted in a comfortable environment, free from potential interruptions and noise. In the introductory phase of each interview, the anonymity of the interviewee was assured, a brief overview of the purpose of the research was given, and the criteria and right to stop the interview were explained.

The *Information sheet and informed consent form* had already been digitally signed. A dictaphone was used to record the interviews, and the information obtained was fully documented. The interview audio recordings were manually transcribed into text on a word-for-word basis, and transcription signs were used during transcribing, indicating nuances in the conversation and allowing a better understanding of the emotions and thoughts of the interviewee. The saturation point was reached by conducting those interviews, as the information obtained started to repeat (Boyce and Neale 2006), and this iterative process of data collection and analysis eventually led to a point in the data collection where no new categories or themes emerged (Kuzel 1999). There was no need to involve any further nurses from that health centre in the study. Saturation was first facilitated by sampling; the sample was adequate – large enough to observe recurring themes – and appropriate, as the interviewees were experts in the phenomenon of interest (Morse 2015). For the best results, the author asked more detailed questions, which ensured that both the interviewer and the interviewee stayed focused on the topic, enabling a more expansive description of the phenomenon (Linnik and Sepp 2023). Between five and ten specific questions are typically developed to delve more deeply into different aspects of the research issue (DiCicco-Bloom and Crabtree 2006). Nurses described their subjective experiences and needs in counselling climacteric female patients. The average duration of each interview was 25 minutes, the longest lasted 32 minutes and the shortest 18 minutes.

2.4. Data analysis

Content analysis is extremely well-suited to analysing the qualitative data on the multifaceted, sensitive phenomena characteristic of nursing. Inductive content analysis was used in the current study. This is recommended when there are no previous studies dealing with the phenomenon or when knowledge is fragmented (Elo and Kyngäs 2008). Deductive content analysis is used when the structure of analysis is operationalised based on previous knowledge, and the purpose of the study is theory testing (Kyngäs and Vanhanen 1999). Qualitative data analysis occurred concurrently with data collection, enabling the researcher to generate an emerging understanding about the research questions, which in turn informed both the sampling and the questions asked (DiCicco-Bloom and Crabtree 2006).

All the recorded interviews were transcribed and marked with pseudonyms known only to the researcher (which all involved the letter 'R' (Respondent): R1, R2, etc., up to R9). The researcher read all the interview texts in detail. The categories were derived from the data in inductive content analysis (Kyngäs and Vanhanen 1999), which provided meaning to describe the phenomenon of the study and to enhance understanding (Elo and Kyngäs 2008; Creswell 2009). The abstraction in the analysis helped to formulate a general description of the research topic through the creation of categories (Elo and Kyngäs 2008). Thus, the transcribed texts were divided into two main themes according to the research tasks. The transcribed texts were analysed by examining the incidents of characteristics, with segments of the analysed text or units grouped based on similarity and labelled accordingly. The similarly simplified expressions were grouped into substantive codes (Elo and Kyngäs 2008). During the coding of the text, it was divided into parts that were later analysed and subcategorised using the received similar substantive codes. After that, subcategories were grouped into supracategories with similar criteria. For example, the formation process of the supracategory 'Experiences regarding patient awareness' is shown in Table 1. Finally, two main categories were formed: 'Nurses' experiences of counselling climacteric female patients' and 'Nurses' needs in counselling climacteric female patients'.

2.5. Ethics of the research

A qualitative study was conducted after gaining permission from Tallinn Health Care College (now Tallinn Health University of Applied Sciences) (Decision No. 216/2022, issued on 27.04.2022) and approval from the Research Ethics Committee of the Estonian National Institute for Health Development (Decision No. 1104 on research No. 2374, issued on 01.08.2022). Prior to each interview, the interviewees signed digitally the *Information sheet and informed consent form*, which confirmed their agreement to participate voluntarily, offering them the option to withdraw from the study at any time. All collected information, consent forms, transcriptions of the interviews, and sound files were retained in password-protected encrypted folders on the computer of the researcher and were available to the author of the research only. The interviews depicted the experiences of the subjects, not the thoughts and interpretations of the author. Quotes were used to demonstrate the results and to increase credibility, while ensuring, as per Elo and Kyngäs (2008), the anonymity and privacy of the participants. This was achieved by giving pseudonyms to the participants and not noting their name, gender, age, or work experience. Adding the age and work experience data of the interviewees may provide an opportunity to identify specific individuals at the given health centre. After completing the research paper, all the transcriptions and audio files were deleted.

3. Results

The results of this research describe the nurses' different experiences and needs in counselling climacteric women in daily nursing practice. The aim of the study was to gain an overview of these experiences and needs. The analysis of the interviews revealed two main categories: 'Nurses' experiences in counselling climacteric female patients' and 'Nurses' needs in counselling climacteric female patients'. The following sections present both categories and their subcategories, along with quotes from the interviews.

3.1. Nurses' experiences in counselling climacteric female patients

The main category 'Nurses' experiences in counselling climacteric female patients' is formed of substantive codes, which are arranged into seven subcategories and then into

Table 1. Formation process of the supracategory 'Experiences regarding patient awareness'

Segment of the text	Substantive code	Subcategory	Supracategory
'*For example, they do not initially suspect that their bladder complaints have become more frequent due to the onset of the climacteric.*'	Patient's insufficient knowledge	Women's awareness of climacteric period changes	Experiences regarding patient awareness
'*They think that it is the beginning of some serious disease.*'	Fear of a serious illness		
'*The climacteric phase starts for these women – and instantly, after their uterus and ovaries have been surgically removed...*'	Pre- and postoperative counselling		
'*People look up all sorts of things on the internet from unreliable sources…*'	Improper online sources		
'*They don't know about these things; I advise, I reassure them…*'	Provided suggestions		
'*Over the years, this awareness has improved…*'	Patient's awareness today		
'*Unfortunately, not everyone is capable or willing to accept this fact...*'	Patient's acceptance	Women's readiness for climacteric period changes	
'*If a person doesn't want to, then yes, it is a bit harder to help them…*'	Some do not want to change anything		
'*Patient said that she read about climacteric period from different sources…*'	They read about the topic themselves		
'*She is ready to collaborate with us and also in her life herself…*'	Readiness to work with themselves		

three supracategories. The analysis of interviews revealed three supracategories: 'Experiences regarding female patients' visits', 'Experiences regarding female patients' awareness', and 'Experiences regarding female patients' counselling'. The formation of the main category 'Nurses' experiences when counselling climacteric female patients' is shown in Table 2.

3.1.1. Nurses' experiences regarding female patients' visits

Based on the nurses' descriptions of the experiences regarding female patients' visits, the analysis of interviews revealed four subcategories: 'Frequency of visits', 'Patients' health complaints', 'Medical history', and 'Patients' referral to a specialist'.

Subcategory (1): Regarding frequency of visits, specifically on the topic of the menopause, the nurses reported a wide range of responses, from 'not very often' to 'perhaps only once a month' to 'two, three, four times a month'. Women do not tend to rush to make the initial visit to the family nurse in connection with their climacteric complaints, instead they prefer to visit a gynaecologist. One of the nurses stated, '*Who are suffering with climacteric issues already know there's something up, and they go to their gynaecologist*.'

Subcategory (2): The nurses mentioned that regarding climacteric female patients' health complaints, women primarily seek help for issues such as fluctuating blood pressure, palpitations, general malaise, fatigue, hot flashes, joint pains, bladder complaints, sweating, breast problems, changes in body weight, mood disorders, or sleep disorders. A participating nurse reported, '*They come to us with a general feeling of malaise, while others come due to anxiety disorders.*', and another nurse stated, '*They can come in with a bladder-related complaint*.'

Subcategory (3): The nurses noted that only the patients' medical histories taken during the visits showed that the reasons for these patients' visits could be related to the climacteric period. One of the nurses said, '*Only after completing the medical history it becomes clear that this may be associated with the climacteric age*.' The nurses did not feel sufficiently confident to take medical histories about the

Table 2. Nurses' experiences when counselling climacteric female patients

Subcategory	Supracategory	Main category
Frequency of visits Patients' health complaints Medical history Patients' referral to a specialist	Experiences regarding female patients' visits	Experiences in counselling climacteric female patients
Women's awareness of climacteric period changes Women's readiness for climacteric period changes	Experiences regarding female patients' awareness	
Experience of counselling as a challenge Experiences with methods of alleviating patients' symptoms	Experiences regarding female patients' counselling	

women's climacteric period; one of the nurses mentioned, '*I don't feel myself so confident to collect medical history to identify and recognise menopausal symptoms. They do come complaining that their joints have started to hurt more, that they get more tired*.'

Subcategory (4): The interviews revealed that in terms of referring patients to a specialist, family nurses referred women to a gynaecologist, midwife, physiotherapist, or osteoporosis counselling service. The nurses mentioned that the work of a family nurse covers such a broad area: '*to know everything about everything*.' They referred patients to a gynaecologist if the history they took showed that the patient had not visited a gynaecologist regularly, as well as if she had hot flushes, mood disorders, or heart problems. The nurses referred women to a midwife with breast problems, to physiotherapist with problems in musculoskeletal system, and to the osteoporosis counselling service if the patient suffered fractures too frequently. One of the nurses said, '*Some women fall and frequently suffer fractures, so we refer them to the osteoporosis office*.'

3.1.2. Nurses' experiences regarding female patients' awareness

Based on the nurses' descriptions of the experiences regarding female patients' awareness, the analysis of interviews revealed two subcategories: 'Women's awareness of climacteric period changes' and 'Women's readiness for climacteric period changes'.

Subcategory (1): The nurses highlighted that women's knowledge is rather limited; patients associated hot flushes, the irregularity of menstruation, and night-time sweating with the climacteric period, but they lacked the ability to associate their other health issues or fluctuating emotional state with it. The nurses also mentioned that 50-year-old women already thought about the menopause, but 40–45-year-old women did not know that their health complaints were associated with the perimenopausal stage. A participating nurse said, '*40-year-old women who come in with bladder complaints, do not initially suspect that their complaints have become more frequent due to the onset of the climacteric*.'

The nurses also mentioned that they had to deal with patients' fears that menopausal changes in the body were the beginning of a serious illness, oncological disease, or a major health problem behind these symptoms. An interviewed nurse stated, '*Some women immediately think of some oncological disease*.'

The nurses noted that both pre-surgical and post-surgical counselling are required, for example, in the case of an oophorectomy or hysterectomy. The interviews revealed that the lack of timely counselling has led to a situation where the post-surgical change in the body comes unexpectedly to the patient. One of the nurses said, '*For these women, the menopause begins immediately after surgery to remove the uterus and ovaries*.'

The nurses highlighted the fact that patients are quick to research the menopause information on the internet, but, unfortunately, they do not look for research-based knowledge. One of the nurses mentioned, '*People look up all sorts of things on the internet from unreliable sources*.'

The nurses made suggestions and gave advice to the patients to increase their knowledge about the menopause and as a means of preventing chronic diseases. A participating nurse said, '*They don't know about these things; I advise them. Additionally, the quality of life improves, and the early onset of chronic diseases is prevented*.'

Subcategory (2): The nurses described different experiences regarding patients' readiness to accept changes in their bodies during the climacteric period. They mentioned that women read up on the subject themselves, and they were willing to work with nurses and themselves after nursing counselling. One of the nurses stated, '*We perform all necessary analyses, and she is ready to collaborate with us and in her life herself*.' The nurses discussed that there were also women who did not accept climacteric changes in their

body; they did not want to change anything in their life and that made nursing counselling more complicated. One nurse said, '*Unfortunately, not everyone is capable or willing to accept this fact...*', and another nurse stated, '*If a person doesn't want to, then yes, it is a bit harder to help her*.'

3.1.3. Nurses' experiences regarding female patients' counselling

Based on the nurses' descriptions of the experiences regarding female patients' counselling, the analysis of interviews revealed two subcategories: 'Experience of counselling as a challenge' and 'Experiences with methods of alleviating patients' symptoms'.

Subcategory (1): The nurses found that counselling women presents challenges. They should have the ability to notice and recognise symptoms that might indicate the climacteric period and menopausal discomforts in women of different ages, even the 35-year-olds. One of the nurses mentioned, '*The climacteric period starts earlier, sometimes even from the age of 35*.'

Most of the interviewed nurses pointed out the fact that counselling initially stems from another problem, but the complaints that are revealed during the conversation with the patient tend to be associated with the climacteric phase. A nurse stated, '*Initially, they still come for some other reasons, for example, I am so tired*.'

The nurses highlighted obstacles that make it difficult to advise patients in the climacteric period as communication difficulties with middle-aged female patients during counselling. A participating nurse said, '*Sometimes it is difficult to talk to some middle-aged women*.'

Subcategory (2): The nurses' experiences of methods of alleviating patients' menopausal symptoms highlighted the importance of regular physical activity. As physical activity tended to remain rather low, they suggested for women gymnastics, walking, swimming, or aerobic exercises. They suggested that patients should get at least half an hour's exercise a day, if possible. One of the nurses mentioned, '*It is traditionally established that one should move for half an hour in a day*.'

Some nurses emphasised the importance of physical activity in preventing osteoporosis and maintaining musculoskeletal fitness and function, as muscle mass decreases over time, particularly from the age of 50. One of the nurses stated, '*Exercise is essential – it helps to maintain your bones and muscles...*', and another nurse said, '*People aged 50+ should start doing more muscle training because muscle mass decreases over time*.'

The nurses pointed out the topic of nutrition for alleviating patients' menopausal symptoms. They highlighted the importance of proper nutrition in terms of helping to preserve the body's functionality and a normal body weight. The nurses mentioned a balanced diet for women, the importance of the plate rule, as well as calcium and vitamin D in the diet for improving the quality of life. Some nurses recommended a balanced diet for women in the case of anxiety and palpitations. One of the nurses stated, '*We come to nutrition when there are areas of complaint concerning anxiety, palpitions ... or body weight, then we can talk about nutrition and physical activity*.'

One nurse who studied to be a nutritionist provided additional nutritional counselling for women by suggesting various foods to achieve hormonal balance. She said, '*I provide quite a lot of nutritional counselling ... there are various foods to achieve hormonal balance*.'

The nurses suggested to women dietary supplements such as vitamin D, clover, and granadilla capsules, as well as over-the-counter products available in pharmacies such as *Climofemin* and *Menostop* capsules. The nurses noted that people are deficient in vitamin D, and it is an effective supplement for fatigue, brain function, metabolism, and joint problems. A participating nurse stated, '*I suggest vitamin D for joint problems*.'

3.2. Nurses' needs in counselling climacteric female patients

The main category 'Nurses' needs in counselling climacteric female patients' is formed of substantive codes, which are arranged into five subcategories and then into two supracategories. The analysis of interviews revealed two supracategories: 'Needs of self-improvement related to climacteric patients' counselling' and 'Needs related to additional resources'. The formation of the main category 'Nurses' needs in counselling climacteric female patients' is shown in Table 3.

Table 3. Nurses' needs in counselling climacteric female patients

Subcategory	Supracategory	Main category
Needs related to collecting patients' medical history Needs related to non-pharmaceutical methods of alleviating climacteric complaints	Needs of self-improvement related to climacteric patients' counselling	Needs in counselling climacteric female patients
Needs for training courses Needs for increasing nurses' motivation Needs for informational material/ website	Needs related to additional resources	

The interviewed nurses highlighted that their needs were primarily related to individual self-improvement, which would serve to increase their own confidence when counselling climacteric female patients.

3.2.1. Nurses' needs of self-improvement related to climacteric patients' counselling

Based on the nurses' descriptions of the nurses' needs of self-improvement related to climacteric patients' counselling, the analysis of interviews revealed two subcategories: 'Needs related to collecting patients' medical history' and 'Needs related to non-pharmaceutical methods of alleviating climacteric complaints'.

Subcategory (1): The nurses identified that the most important need is related to taking patients' medical history as well as recognising and identifying their menopausal symptoms. All nurses felt insecure about counselling climacteric women. A participating nurse said, '*I don't feel myself so strong to collect medical history to identify and recognise* [menopausal symptoms]; *they do come complaining that their joints have started to hurt more, that they get more tired*.' The nurses mentioned difficulties at establishing initial contact when collecting patients' medical history. They highlighted also the importance of improving motivational communication and counselling techniques when collecting patients' medical history and advising them. One of the nurses stated, '*The more I know about counselling tips, the better I can advise a menopausal patient*.'

The nurses needed a better overview of the variety of specialists available for further advice. Referrals to midwives and gynaecologists were much more common if they realised that the health problems were related to the climacteric period; however, the nurses' knowledge about evidence-based specialists in the musculoskeletal disorders or nutrition were insufficient. A participating nurse mentioned, '*I know the osteoporosis office, but not all the musculoskeletal issues are for them*.'

Subcategory (2): The nurses highlighted the need for non-pharmaceutical methods of alleviating menopausal symptoms. They mentioned that their knowledge base should include knowledge of yoga exercises, which can be very supportive for the musculoskeletal system and the mental health of middle-aged women. One of the nurses said, '*Yoga exercises are very supportive for middle-aged women's mental health, for joints and muscles, but I need some exercises to show them*.' The nurses valued yoga as a non-pharmaceutical method for alleviating menopausal symptoms but could not recommend a specific style. A participating nurse stated, '*Yoga is good, but there are so many variations. I need to know more*.'

The nurses pointed out a need for non-pharmaceutical methods to alleviate sleep disorders. A participating nurse stated, '*I am interested in, and often need, methods of alleviating sleep disorders*.' The nurses also mentioned a need for non-pharmaceutical methods to alleviate mood disorders. The nurses mentioned, '*Measures or tips for mood disorders would be very useful, everything changes so quickly now*.'

3.2.2. Nurses' needs related to additional resources

Based on the nurses' descriptions of the nurses' needs related to additional resources, the analysis of interviews revealed three subcategories: 'Needs for training courses', 'Needs for informational material/website', and 'Needs for increasing nurses' motivation'.

Subcategory (1): All nurses from the study mentioned the need for training courses. They highlighted that there is a lack of training courses on the climacteric period, menopausal symptoms, how to relieve them with non-pharmaceutical methods, and about counselling for menopausal women. A nurse said, '*It would be good to have specialised training on symptoms and how to alleviate them...*', and another stated, '*I don't see the topic of the climacteric there in the training calendar at all*.'

The nurses also noted that there are many courses on diabetes and asthma, also a possibility to take part in the annual women's health conference, but training regarding the climacteric period is mainly available for midwives. One of the nurses mentioned, '*But regarding the menopause, I have never heard of any…*', and another nurse said, '*If* [there are] *some training courses, then mainly for midwives*.'

Subcategory (2): The nurses pointed out the need for informational material or a website. They discussed that there is a lack of informational leaflets, evidence-based informational materials or a website about women's health and well-being. These could be given to patients about menopausal symptoms, alleviating methods, etc., so that they can educate themselves and find information easily. Half of the nurses stated, '*I could give a brochure or something like that, where the most important things are collected.*', and some of them highlighted, '*It would be nice to have a very practical informational leaflet, something supportive as we have different leaflets on minerals and vitamins*.' Some nurses considered it necessary to create a unified website addressing women's health and well-being, serving as a tool for healthcare professionals and as reading material for patients. One of the nurses said, '*I miss a website about women's health; it would also be useful for nurses themselves, and I could recommend it to my patients*.'

Subcategory (3): The study found that nurses had needs for increasing their motivation to learn more or to do their work better. Some nurses felt that their efforts in learning and self-development should be better rewarded by the employer, as attending training courses was an extra effort, and one of them lacked motivation to do her job. A participating nurse said, '*Attending training courses is an extra effort, and this should be reflected in the salary*.'

Some nurses mentioned the need for increasing the motivation of nurses in primary health care, and one nurse suggested that the nurses' areas of specialisation, as is the case for doctors, should be used to increase the motivation of family nurses. She stated, '*Something so that you could feel a little more competent in certain fields, not necessarily knowing everything, but just be able to cover an extra two or three fields*.'

Two nurses pointed out the need for a special programme on national television to encourage women to visit the family nurse to discuss their menopausal concerns and seek advice, as the media have been encouraging men to consult the health professionals. A participating nurse stated, '*There could be a special programme on national television for women to go to a family nurse with their menopausal symptoms*.' One of the nurses mentioned that the posters on the walls may encourage women to visit the nurse to discuss their menopausal concerns and seek advice. A participating nurse stated, '*There could be a poster on the wall to encourage women to go to a health check-up*.'

4. Discussion

The aim of the study was to gain an overview of nurses' experiences and needs in counselling climacteric women in daily nursing practice. No studies have recently been conducted about the experiences or needs of family nurses in this area in the Estonian context.

The study found that nurses' needs were primarily related to individual self-improvement, which would serve to increase their own confidence when counselling climacteric female patients. Nurses felt insecure about counselling menopausal women; they had doubts in collecting patients' medical history and recognising menopausal symptoms. These findings were considerable and also unexpected, as, according to Peacock et al. (2023), nursing tasks in the case of a climacteric patient should include the preparation of an in-depth medical history and an assessment of vital signs. Previous studies have also emphasised that nurses supporting midlife patients need to know the various symptoms of the menopause (Richardson et al. 2023) and must be able to identify the patient's problems and needs (Vasiloglou et al. 2019). This study revealed that women seek help from nurses for issues they do not associate with the menopause; however, based on their symptoms and complaints, the conditions of middle-aged women may be linked to the menopause. The study demonstrated that the connection between health complaints and the climacteric period was primarily identified through conversations and the collection of medical histories. This finding aligns with previous research by Hoga et al. (2015) and Hickey et al. (2022), who also emphasised that women experiencing menopausal health complaints most commonly seek help for issues such as fluctuating blood pressure, heart palpitations, general malaise, fatigue, hot flashes, joint pain, bladder problems, sweating, breast problems, changes in body weight, as well as mood and/or sleep disturbances. Since the study identified the nurses' main needs as related to collecting patients' medical histories, this should be taken into consideration in nursing curricula, and additional training courses should be prepared for working nurses. Increasing nurses' knowledge would also enable them to provide support for middle-aged women, leading to more satisfied patients and, ultimately, improving the quality of health care.

Additionally, the study found that women's awareness of menopausal changes was limited. Patients rarely scheduled appointments with nurses at health centres specifically to address menopausal symptoms. Unexpected moments occurred during visits, as the women were unable to associate their health problems or fluctuating emotional state with the menopausal years. This finding aligns with previous research by Harper et al. (2022) that women are unaware that the symptoms they experience may be related to the climacteric period and can manifest in biological, psychological, or social contexts. The study is in line with previous findings (Marlatt et al. 2018; Lillis et al. 2021; Harper et al. 2022; Aljumah et al. 2023) that nurses deal with patients' fear – climacteric changes in the body are taken as the beginning of some serious disease, oncological diseases, or bigger health problems behind these symptoms. Several researches confirmed the situation that women feel unprepared when it comes to the climacteric period of their lives, and they lack important knowledge about what to expect and how to optimise their health (Marlatt et al. 2018; Lillis et al. 2021; Harper et al. 2022; Aljumah et al. 2023). The current study found that women who were awaiting or had undergone gynaecological surgery also needed advice from the nurse; for example, the surgery caused some women to reach the menopause earlier than expected. According to Holloway (2017) and WHO (2024), the menopause can also be induced because of surgical procedures that involve the removal of both ovaries and medical interventions that cause cessation of the ovarian function. Thus, menopausal and postmenopausal health management is an important issue in all areas of health care, not just in gynaecology (Calow et al. 2023).

The study emphasised that all nurses highlighted regular physical activity as the most efficient method for remaining in good physical and mental shape and for helping to alleviate woman's menopausal complaints. The nurses suggested gymnastics, walking at least half an hour a day, swimming, and aerobic exercises for patients. Also, they recommended physical activity for women to prevent osteoporosis and maintain musculoskeletal strength and function, as the muscle mass decreases over time, especially after the age of 50. Encouraging regular physical activity in nursing counselling is a viable strategy that can improve women's well-being, alleviate menopausal symptoms, reduce the risk of chronic diseases, and improve their quality of life (Curta and Weissheimer 2020).

The study revealed that nurses needed to improve their motivational communication and counselling skills in order to provide menopausal women with better advice. Additionally, the study found that all nurses pointed out the need for training courses, as there was a lack of training in menopausal symptoms, alleviating non-pharmaceutical methods, and counselling for menopausal women. The nurses mentioned that, when training on the topic of the menopause was available, it was primarily aimed at midwives. Nurses' lack of training also seems to encompass a larger area than just the local context, according to Harper et al. (2022), Aljumah et al. (2023), and WHO (2024). Healthcare professionals' lack of adequate training in managing the menopause means that women enter this critical life stage uneducated and un-

supported. Aljumah et al (2023) and Calow et al (2023) have emphasised that nurses should be equipped with the knowledge and skills to support women through this critical life transition. The study revealed that some nurses needed to be more motivated to develop themselves and do their daily work, and that their efforts in learning and self-development should be better rewarded by their employer. Some nurses mentioned that attending training courses needs an extra effort. According to Linnik and Sepp (2023), it is recommended that healthcare organisations provide adequate resources and support systems to help nurses to manage their workload, improve communication and the organisational culture, and provide adequate training.

As the global population of post-menopausal women is increasing and, according to Richardson et al. (2023), the perimenopause is often perceived as a hidden phenomenon, educational programmes should include the menopause as a component. The results and knowledge gathered within this research are planned to be used practically to improve the pre-service curricula in nursing, and it is therefore essential that the subject is given greater prominence in nursing curricula. A better understanding by nurses of the health concerns and needs of menopausal women could provide the basis for more patient-centred and effective care. Strengthening nursing education will increase patient-centredness and improve knowledge and care for midlife women.

This work could draw attention to the need to improve understanding of the menopause by promoting its inclusion in training and fostering a more supportive environment for menopausal women. It is in line with wider global health priorities to improve patient awareness and training for nurses in primary health care. From a global health perspective, it is vital to ensure that patients remain healthy for as long as possible. In order to achieve this, however, it is necessary to increase women's awareness of the climacteric period and the measures that can be taken to alleviate it. Although the majority of women do not immediately seek medical help for their menopausal health problems, this does not diminish the importance of nursing care. On the contrary, it increases the need to raise women's awareness of this issue.

This study has some limitations. The participants worked in the same health centre; therefore, the results cannot be generalised to all Estonian nurses working in primary health care. Participants were not asked personal questions about the college of nursing and the time since graduation. The reliance on self-reported data may also introduce bias, as participants' responses could be influenced by personal experiences or recall limitations. Expanding the sample size and including a mixed-methods approach – combining qualitative interviews with quantitative surveys – could offer a more comprehensive understanding of the challenges and opportunities in menopause counselling. A comparative study involving nurses from different healthcare settings or geographic regions would enhance the generalisability of the findings. Additionally, the study focuses solely on nurses' perspectives, without direct input from patients, which could provide a more balanced understanding of menopause counselling experiences.

Although there are limitations, the findings remain valuable, as no recent studies have been conducted on the topic in the Estonian context. The proposed collaboration between Tallinn Health University of Applied Sciences and the Estonian Union of Family Nurses enhances the study's credibility and practical impact. The findings of the study provide valuable insights for planning the content of nursing curricula for students and for establishing a continuing education programme for family nurses. They also offer an impetus for the Estonian Union of Family Nurses about the important role of the nurse as the primary counsellor in the case of climacteric health issues of middle-aged women. Additionally, these findings point to the need for further research on family nurses' counselling of menopausal women in Estonia. Incorporating patients' perspectives should be considered as a possibility for further study. Understanding how climacteric women perceive the quality and accessibility of counselling from family nurses could provide deeper insights into existing barriers and unmet needs of nurses.

5. Conclusions

The main findings from the study regarding nurses' experiences were that the consultations presented challenges to them, and all the nurses felt insecure when counselling climacteric women. Although the nurses were aware of the middle-aged women's fears and their communication difficulties, it was noteworthy that the nurses had problems with recognising menopausal symptoms and completing the patient's medical history. Nursing tasks in the case of a climacteric patient should include preparing an in-depth medical history, the lack of which has identified the gaps in nurses' training. Additionally, middle-aged women's awareness of menopausal changes was limited, and they obtained information mainly from non-medical sources. The study found that the nurses promoted a healthy lifestyle for patients, considering physical activity and a balanced diet very important in counselling. The nurses emphasised exercise, nutritional support, and the need to improve patients' knowledge of the menopause, all climacteric periods, healthy lifestyles and non-pharmaceutical alleviation methods, confirming that nurses as primary care counsellors play a crucial role in health care.

The need for training was strongly identified in the study. The professional development of nurses is very important to ensure the provision of high-quality care. The study found that it was equally important to improve nurses' motivational communication and the knowledge of non-pharmaceutical methods for alleviating menopausal complaints. Nurses needed to improve their knowledge about the specialists in musculoskeletal disorders and evidence-based nutritionists to whom patients could be referred. Additionally, some nurses mentioned that their efforts in learning and self-development should be better rewarded by the employer, as attending training courses was an extra effort.

Based on the study's findings, several key recommendations can be made to enhance nursing education, interdis-

ciplinary collaboration, and patient-centred care for midlife women. Based on the results, it is recommended that nursing curricula be updated to include evidence-based knowledge on menopause management, non-pharmacological interventions, and patient-centred counselling strategies. There is a need to raise nurses' awareness of menopausal issues during their undergraduate studies in order to increase their capacity to provide high quality, appropriate care. Additionally, ongoing training and education should focus on enhancing working nurses' competence in identifying and addressing menopause-related health concerns. Regular interdisciplinary training should be taken into consideration, as it would facilitate cooperation between specialists. Strengthening collaboration between nurses, general practitioners, and gynaecologists is essential for improving menopause care in primary health care, which could lead to more satisfied patients.

Future research should explore effective methods to increase patient awareness, ensuring that women receive accurate, evidence-based information. Further studies are also needed to assess the effectiveness of different counselling approaches, the impact of physical activity interventions on menopausal symptoms, and patients' perspectives on primary health care support. Implementing these recommendations will help to improve health services and the overall well-being of women in midlife.

Data availability statement

All research data are contained within the article and can be shared upon request from the author.

Acknowledgements

The author would like to express gratitude to the study participants and the partners from the health centre in Pärnu City who helped to recruit the participants. Many thanks also to the nursing students Dagmar Lelle, Jelena Frischer and Liisa Fomichev who contributed to the study. The publication costs of this article were partially covered by the Estonian Academy of Sciences.

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Pereõdede kogemused ja vajadused üleminekueas naispatsiendi nõustamisel

Marelle Grünthal-Drell

Paljud üleminekuea sümptomitega naised otsivad esmast terviseabi perearstikeskusest. Pereõed peaksid olema piisavate teadmiste ja oskustega, et hoolitseda naispatsientide tervise eest ja juhendada neid läbi selle kriitilise elumuutuse. Uuringu eesmärk oli saada ülevaade õdede kogemustest ja vajadustest üleminekueas naiste nõustamisel igapäevases õenduspraktikas. Kvalitatiivne uuring viidi läbi poolstruktureeritud intervjuude abil. Pereõed tõid välja, et sageli pöördusid patsiendid vastuvõtule mitme terviseprobleemiga, mida nad ise ei seostanud üleminekueaga. Õed tundsid end üleminekueas naiste nõustamisel ebakindlalt, kuna see esitas neile erinevaid väljakutseid. Õed rõhutasid tervislike eluviiside propageerimise olulisust, sh regulaarset kehalist aktiivsust kehakaalu normaliseerimiseks, osteoporoosi ennetamiseks ning luu- ja lihaskonna funktsiooni säilitamiseks. Samuti tõsteti esile vajaduspõhist toitumist, et toetada elukvaliteeti, vähendada ärevust ja südamepekslemist ning saavutada hormonaalset tasakaalu. Pereõdede vajadused olid eelkõige seotud professionaalse arenguga suurema enesekindluse saavutamiseks patsientide nõustamisel. Kõik õed tundsid vajadust täiendada teadmisi anamneesi kogumisest ning üleminekueaga seonduvate sümptomite tuvastamisest. Mitmed tõid esile motiveeriva suhtlemise ja nõustamistehnikate koolituse vajaduse, kuid asjakohaseid koolitusvõimalusi ei leidunud. Lisaks tunti huvi konkreetsete praktiliste tööriistade, näiteks joogaharjutuste vastu, mis aitaksid leevendada patsientide une- ja meeleoluhäireid. Mõned õed märkisid ka vajadust suurema töötasu järele. Oluliseks peeti infovoldikuid ning ühtse, naiste tervisele ja heaolule pühendatud veebilehe loomist, mis oleks kasulik, teaduspõhine ja informatiivne abivahend nii tervishoiutöötajatele kui ka patsientidele.