



DOCENCIA - INVESTIGACIÓN

“There, I endured my pain”. Sociocultural and economic context of women with coronary syndrome in Cali and other municipalities in the Valle del Cauca

“Ahí me aguanté mi dolor”. Contexto sociocultural y económico de mujeres con síndrome con coronario residentes en Cali y otros municipios del Valle del Cauca

***Valencia Micolta, Susana Genith *Rodríguez Torres, Estela**

*Nursing. Mg SP. E-mail: svalenci09@gmail.com **University of Santiago de Cali. Colombia.

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ABSTRACT

The research is part of the Multicenter Research "Comparative characterization of the symptoms of angina in women in eight cities of Colombia."

It addresses the conditions of inequality in employment, education, gender and ethnicity, violence and forced displacement, physiological factors that trigger a variety of symptoms and the appearance of coronary syndrome, angina and acute myocardial infarction.

Objective: To determine socio-cultural and economic factors that affect the onset of symptoms of angina in women from Cali and Valle del Cauca municipalities.

Material and methods: Descriptive qualitative study in 23 women with background of having experienced discomfort, chest pain or discomfort, hemodynamically stable, coronary arteriography vessel injury increased 70%, and post-acute coronary syndrome. The interviews are analyzed with the content analysis technique of Klipendorf and the Theory of Unpleasant Symptoms by Lenz and colleagues.

Results: Unpleasant symptoms are related to physiological background and factors of physical, family and social environment. Findings related to work and domestic responsibilities, assuming roles, family support and coping with their difficulties, living with uncertainty and insecurity, relationships with the environment, complying with treatment.

Conclusion: The way of life in women with acute coronary syndrome, is an influential factor in the worsening of symptoms. Women are exposed to disadvantageous experiences and environments in conditions of vulnerability and inequality.

RESUMEN

La investigación forma parte del “Estudio Multicéntrico, Comparación de la caracterización de los síntomas de angina en la mujer en ocho ciudades de Colombia”. Aborda las condiciones de desigualdad en empleo, educación, género y etnia, situaciones de violencia y desplazamiento forzoso, factores fisiológicos que desencadenan una serie de síntomas y aparición del síndrome coronario, angina e infarto agudo de miocardio.

Objetivo: Determinar aspectos socioculturales y económicos que influyen en la aparición de síntomas de angina en mujeres de Cali y municipios del Valle del Cauca

Material y método. Estudio descriptivo con abordaje cualitativo, en 23 mujeres. Con criterios de haber experimentado molestia, dolor o sensación de disconfort torácico, hemodinámicamente estables, arteriografía coronaria con lesión de vasos mayor de 70%, y postsíndrome coronario agudo. Las entrevistas son analizadas con técnica de análisis de contenido de Klipendorf y Teoría de Síntomas Desagradables de Lenz y colaboradores

Resultados. Los síntomas desagradables, tienen relación con antecedentes fisiológicos y factores influyentes del ambiente físico, familiar y social. Emergen categorías acerca de responsabilidades laborales y domésticas, asumir roles, apoyo a la familia y conviviendo con sus dificultades, viviendo con incertidumbre e inseguridad, relaciones con el entorno, cumpliendo con el tratamiento.

Conclusión. El modo de vida en las mujeres que padecen de síndrome coronario agudo es un factor influyente en el agravamiento de los síntomas. Las mujeres están expuestas a experiencias y entornos desventajosos en condiciones de vulnerabilidad e inequidad.

INTRODUCTION

In the world is estimated that 17 million people have died from cardiovascular diseases (CVD), and are the leading cause of death in the region of the Americas ^(1,2), in the year 2007 they were responsible for almost 1.6 million deaths ⁽³⁾; and they were dominated by ischemic heart disease in 43% of CVD deaths, affecting both sexes ⁽⁴⁾ and over 80% occur in low- and middle-income countries, among which is Colombia.

According to the National Statistics Department (DANME) the group of cardio-vascular diseases (CCV), is the first cause of mortality in both sexes, ischemic heart disease in women occupies the leading cause of death in all ages ⁽⁵⁾. In 2011 the highest proportion of deaths from CVD corresponding to 25.4% was recorded, the risk of dying increases with age, presenting mortality rates above the national rate in one of the departments such as the Valle del Cauca ⁽⁶⁾; which it has 4,532,378 inhabitants, in 2005 it was reported that CVD mortality such as acute myocardial infarction have a rate of 29, 21 hypertensive heart disease, other cerebrovascular diseases 22, primary essential hypertension 11, and ischemic chronic heart disease 11 per every 100,000 inhabitants ⁽⁷⁾. By 2006 chronic ischemic heart disease presented 406 cases, being the tenth leading cause of mortality. Deaths related to major cardiovascular diseases have remained stable; in 2007 there was an increase in the relative rate of 18% compared to 1998 of ischemic heart disease ⁽⁸⁾.

In the process of demographic transition, the aging population is increasing, and changes in lifestyle are impacting directly on the epidemiological profile of the population; this is reflected in the increase in NCDs Chronic (NCDs), in this group Heart Disease and Acute Coronary Syndromes (ACS) are included, it should be remembered that those who suffer from these diseases has been exposed to experiences and disadvantageous environments accumulated over lifetime increasing the risk of disease and premature death ⁽⁹⁾. Hence, there are inequities and social and health inequalities that determine the risk and vulnerability of suffering an illness.

Understanding vulnerability as a dynamic process established by the interaction of its components, such as age, race, ethnicity, poverty, education, social support and presence of elements aggravating health. It is recognized that each person has a threshold of vulnerability when is exceeded disease appears ⁽⁷⁾. For this reason it is necessary to promptly identify risks and vulnerabilities, to provide permanent care, prevent further complications and serious consequences affecting the individual and family welfare and even death.

In the study related situations influencing factors are analyzed, it was necessary to articulate risk factors, taking into account those who make women more vulnerable. Given these determinants, which according to the commission "Social Determinants of Health (CSDH) are classified as structural, which in turn shape the determinants intermediaries"⁽¹⁰⁾. The educational level of women affects the positioning in the working scale and labor income; also here ethnicity and gender relations are located, from this perspective, the conditions of inequality had led women to adopt habits and lifestyles that added to biological and psychosocial factors have detrimental effects on their welfare affecting the quality of life, where events such as coronary syndrome, angina and myocardial infarction occur. These studies generate evidence aimed to rethink strategies and actions to change the profile of morbidity and mortality through the application of knowledge about modifiable risk factors and resilience ⁽¹¹⁾; the results allow to provide strategies care for women from a welfare model in health promotion and prevention of risk in a timely manner and generate proposals that are articulated in design and management of public policies that determine for broad sectors of the population, the difference between survival and death, between enjoying the experience of life and not be subjected to harsh conditions of existence ⁽¹²⁾ in the passing of life when adult women assume and face responsibilities with a high emotional charge.

The coronary syndrome in the female population represents influential factors that are present in the onset of symptoms, which women once suffered should face them. It is necessary to recognize the characteristics of the context in which they operate, including different aspects: among these is the scenario in employment and position of women in a labour market that economically at least allows to satisfy basic needs and the relationship with the accessibility to health services, the Pan American Health Organization ⁽¹³⁾ emphasizes that the gender perspective must be incorporated in health policies and strategies, to give full account of reality, considering that health equity is consistently associated with principles of social justice and human rights.

From this perspective, for health care the gender equality implies that resources and services are allocated respectively according to the specific needs of men and women according to the characteristics of those groups. In general we can say that the vallecaucana woman represents African ethnic groups, indigenous and mestizo product of settlements since colonial times, especially when blacks are brought into the country for work in agriculture and to work in domestic service, "phenomenon which is part of the dominant epicentre condition that has historically practiced Cali, municipality with a majority of black people like most of the municipalities in the geographic valley of the river Cauca, at least until 1920" ⁽¹⁴⁾, there is also another aspect that has been present since the early twentieth century, the violence. Violence has occurred for many decades in certain regions during the armed conflict in which women have had to forcibly migrate with their children, becoming single mothers whose performance in society is shown by the study of Guevara ⁽¹⁵⁾, which realizes the characteristics of the three ethnic groups that predominate in the region such as:

indigenous women who when they reach their new lives create and generate survival and inclusion mechanisms in the condition of internal displaced people , but always trying to preserve their family, regional and gender identity, since the armed conflict also goes through family and individual life leaving a mark on people, fragmenting and polarizing the identity references. In the case of African descent whose close and extended families are numerous, they establish social networks as a mean of solidarity to surround themselves in case of parenting needs, and they perform identical activities of the people already established in the territory before, and finally the group of mestizo, continue to maintain communication with their relatives out of town, but also play roles in domestic service and jobs from the informal economy , it should be noted that when other researches are reviewed the situation is the same in other municipalities ⁽¹⁵⁾.

In addition to the aforementioned situation another essential element that has to do with welfare is employment, whose necessary pay to meet basic needs and direct relationship of affiliation with the social security health, in the Valley Cauca 60% of workers suffer from problems related to poor quality of employment by the dissatisfaction with the income and working hours , in recent years the proportion of men employed in the informal sector has declined continuously, while the rate of female informality has remained high and stable.

It is also clear that women usually suffer a higher level of underemployment ⁽¹⁶⁾, being able to access health services through SISBEN, involving a number of administrative processes to achieve health services in periods of time; situation that leads alternately to use popular health practices, such as the acquired knowledge from generation to generation through folk medicines and what the one that offer healers networks and apothecaries as part of the own collective identity of the popular sectors generating great benefits for people in their daily lives and symbolic universes ⁽¹⁷⁾ because there are many situations that lead women to minimize the problem when it appears, that have to do with the obligations and responsibilities as a woman head of household, mother, grandmother, mother, counsellor, like dealing with situations of violence and insecurity, in addition to economic difficulties; carrying out these roles neglecting themselves creating a strong connection to the spiritual, religious practices, attending worships to pray for their health, negotiate through promises and using folk medicine, only when the situation becomes severe and chronic is when they attend health institutions.

The theory of unpleasant symptoms includes three components ⁽¹⁸⁾ that should be taken into account: the symptoms that the person experiences, the influencing factors that affect the nature of the experience of symptoms, and consequences. It is claimed that the psychological, physiological and situational factors may interact with each other and their relations with the symptoms, there is a relationship between the influential factors that consider physiological, psychological and the situational variables that have been studied, it is considered that when there is social support situational factors are a good cushion stress when the symptom is experienced. When social interactions are influenced negatively alter the physiological state, experiencing anxiety, depression and modification of daily activities. The application of theory allows to interpret and understand the dimensions of the symptom as negative experience, and to identify the influencing factors and consequences, to guide nursing interventions.

The objective of the research is to determine the socio-cultural and economic factors that influence the onset of symptoms of angina in women of Cali and Valle del Cauca municipalities.

MATERIAL AND METHOD

The research was conducted in the period 2010-2011. It is a descriptive study with qualitative approach, applying the content analysis technique ^(19, 20). From registration units and context units there were identified categories, according to the three levels of semantics: syntax refers to the analysis of the surface of the text, the semantic meaning of words and phrases situation is explored; focusing and pragmatic language as a subject behavior in context, reflecting the meanings of the experience of a situation and explain associated behaviours' ⁽²⁰⁾, from an emic perspective. To determine the methodological rigor of the study criteria of credibility, auditability and transferability ⁽²¹⁾ were taken into account.

The study was approved by the ethics committees of the institutions committed to the development of the research, taking into account the ethical principles ⁽²²⁾ of confidentiality and anonymity, voluntary participation of women who entered the study once they signed informed consent. For the sample, the criterion of data saturation ⁽²³⁾ was applied, 23 women who consulted at two health institutions of high complexity in the city of Cali, meeting the following inclusion criteria: that they had experienced pain or feeling of discomfort in the chest; and that at the time of the interview were hemodynamically stable with coronary arteriography with an injury of more than 70% in one or more vessels or that had post-acute coronary syndrome, and who were from the city in which they were hospitalized.

In-depth interviews were conducted, from a semi-structured guide, transcribed and simultaneously analyzed the data with the content analysis technique⁽¹⁹⁾, based on the expressions through verbal and body language that allowed to identify and interpret data since the formation of sampling units ⁽²⁴⁾, which include the general account of the lived and felt experiences by participants in relation to the dimensions of the unpleasant symptoms, factors that determine it and the consequences of that experience. Once coded the information registration and context units were formed, identifying and analyzing the data for understanding the meanings of behavior ⁽²⁵⁾, the semantic and syntactic expressed in the substantive codes, and interpreted from the perspective of the emic; considering the particular gender in our particular case: the women from Valle del Cauca region. Finally described in categories, sub-categories and taxonomies, synthesizing, contextualizing and recontextualizing ⁽¹⁹⁾ the phenomenon from the theory of Lenz et al. as theoretical foundation of care. However it is worth noting the thoughts that necessarily must be made at time of analysis and talking about the component of influential factors, the researchers interpreted from the context of public health as corresponding to those determinants in order to rethink actions from health promotion and disease prevention. Also regarding women, it implies addressing gender conceptualization and epistemic reflections from a social and historical interpretive framework especially when it is about our Colombian context.

RESULTS

Within influential factors there are determining situations that include: the influence of family, society, work, living conditions, access to services; and the physical

environment (heat, humidity, light, and air quality). They set out the relevant categories, according to the theory of Lenz; and in each, the subcategories from the pragmatic approach as expressed in the language behavior of subjects in context. The 23 women participating in the study are between 45 and 75 years old; they belong to the mestizo and Afro-American ethnicity. As for marital status: 39.1% are widowed, 13% cohabiting, separated 13%, 13% are single and 9.4% are married. 91.3% had some schooling, complete primary being the highest level achieved, and 8.7% illiterate. Regarding their occupation 17.4% are retired, 13% are workers, 8.7% are unemployed and 52.2% are housewives, this last characteristic is consistent with the findings in a group of women who participated in the study from Girardot municipality⁽²⁶⁾, other findings indicate some similar lifestyles characteristics in geographical areas of Colombian riverbanks, as described below:

Category 1. Compliance with domestic work and responsibilities

Participants develop in contexts of formal and informal work independently with the majority in domestic trades, in the workplace they present signs and symptoms of discomfort, but still complying with their chores because their home depends on their income:

"Yes, yes, when I was working, well I had to do the: sweeping, mopping, washing bathrooms, dusting, and washing walls (She is thoughtful and takes a deep breath, nods). Then I went to work and spent all day with little pain, a little pain (repeatedly touches the chest with a fist hand) "

"The first thing that hit me was when I was at the company that's where I realized. I struggled ... with that discomfort and that was here in the emergency room, because I came ... then I told the head nurse, that were two bread toasts that had gotten stuck and I was working and I was turning blue and I hadn't realized ... "

"And you have to finish lunch. Because look you have to ... because I work with lingerie, I have to deliver a tablecloth ... I have my girl school meeting ... that money to pay for services and all that ..."

In the presence of the event a woman may tell herself that is not worth to worry, but when the phenomenon is repeated the ability to resist and endure is depleted, and in extreme gravity they do turn for help.

"... No that is, sometimes they know me, and say look ...let's call Mrs xxxx. To do house cleaning, sometimes because if, say lately I refused, for that pain thing. "

"I worked in a school. I had to do everything, to go to the bank, I played all roles, stationery all those. Until I got retired, plus I worked two more years after my retirement. I worked all my life there ... did not work somewhere else but there. "

Note that some women identified their role as "housewives", an activity that has been a full-time job without any recognition at home and as a job remains available as cheap labour. As expressed:

"See that poor woman, rest ... perhaps the one with money. Because we the poor ... that sweeping, the mopping, the washing, making food, care of the husband "if she has a husband," if not the children, and you spend all day doing cleaning and never ends ... let's not tell lies, we women don't rest! The rich ones maybe... "

"No well, I had the pain and. and ... I did not tell the family well, because you need to do the chores and take care of the family. "

Category 2. Assuming the role of wife, mother, grandmother, mother

The largest group of women are widows, followed by separate and single; they lack of a marital relationship, and described the experience:

"I do not know or would be because of it... because the father of my children left me, and you know you always, anyway ... I was 18 when I went out with him. ... He never mistreated me. And he showing women in front of me ... because they said it was the disease of a broken heart, that he had caused it because I thought a lot, I cried a lot. ... He lives right there next to my house. "

Women are routinely operating with greater participation in decision-making of any kind, with different members of the family: children, grandchildren, and daughter.

"You know that at that age a girl begins to ah ... and if you let them, and if you let them come then they come with one in the oven, with its tamalito and then that's what you have to avoid (place your hands on abdomen, simulating enlargement), and smiles. "

"Yes, strong emotions, because they are so intense, if my mom ate, the son that gets drunk a lot, is very bully, is already drunk, and the phone rings and they will say that he is drunk,... and very troublemaker "

"For example, I tell them: look at this, for example, I struggle a lot with children. I am hoping that the mother comes, to give them to her because honestly, no. Not anymore, today is very difficult to manage childhood, difficult, difficult. Not when you raised your children, I raised my children myself. No fighting, I did not hit my head with them both. "

"Mother in law give me a rice soup, you make it good, then I made it, I went and made it. When I was making it, the little pain tried to start. When I shook a lot, or when I argued with my child, or arguing with my daughter in law, or something like that ..."

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lot, or when I argued with my child, or arguing with my daughter in law, or something like that ..."

Category 3. Supporting family and living with their difficulties

In some villages of the region there are environments of uncertainty causing women fears for the safety of their family.

"... And partly what I had ... I think the anxiety because my son is in jail, the theft, robbery that I suffered on Sunday. The day before, that they robbed me ¡No! I have no phone, I have no way to call ... I was left alone, we got lost for this, because the phone was.... "

"And the second day the icing on the cake , they said, that my son was killed by one of those groups..., it was all a misunderstanding, someone said one of those groups, those Rastrojos, I don't know, they killed XXXX, imagine that, How my condition was not going to be worse... "

Participants expressed that besides of their roles, they have the protective function and when there is family dysfunction their emotional state gets affected;

"... Any argument with the children gives me a discouragement in the body."

"... For example bad news; I have a son who is late and I tell him to drive carefully, and I have a son who drives a bike too and I say be very careful ..."

However, some participants expressed that not everything is bad, be accompanied and surrounded by family and neighbors make them feel like they have reciprocal emotional support and also contribute to their health care.

"My children who are the two who are here with me. They were taking care of me, until now. Because, for them, now that I am hospitalized, they are here to visit me. "

"I was alone, as I say, alone, so I went to the balcony and started screaming; to call the neighbors, the neighbor who was in front. ... And then I said, I said as I could: Please help! Please help me!"

Category 4. Interacting with the environment

This category is related to living conditions and social environment influences, their sources of income at the individual and household level, access to health services and response that are in accordance with certain conditions of the physical environment such as heat, light, moisture, and air quality among others. Meeting the following subcategories:

"LIVING WITH UNCERTAINTY FOR INSECURITY"

Some of the participants especially those in rural areas express that they live facing situations of violence and insecurity.

"They said, that my son was killed by one of those groups..., it was all a misunderstanding, someone said one of those groups, those Rastrojos, I don't know, they killed XXXX, imagine that, How my condition was not going to be worse... "

"Well nothing, because I was asleep, woke up with that burning sensation, was not thinking; Ah!! It was a shock, now that I remember I was scared, I was asleep, quiet, when I felt a few steps down the corridor, you imagine in a farm, and feel, a few steps down the corridor, and I jumped straight away ..."

"REACTING TO CHANGES IN CLIMATE"

When presenting symptoms the most common expression is related to the lack of air and temperature changes.

"I could not walk not even a block, I had that fatigue and then pain like that, then I had to sit around in any front yard and stay there until I had caught my breath ... So I endured, endured, until I got a heart attack immediately, one endures, that leg fatigue, and lack of air, I used to go to the window for breathing."

"But I say no, ... the pain started , and I said this is all that this lady told me, but then, in one arm had to start before coming," I did not think " Me that pain, and that arm pain, but not strong because I came and I wrapped a rag because maybe it was due to the cold ... "

"SO I DIDN'T HAVE ANY MONEY FOR PAYING"

Is notable the income deficit related to the activities carried out by women at home without any pay and others who work in the informal sector, the absence or lack of money to supply basic household needs makes housewives to have very strong emotions with intensity, creating internal conflict and stress.

"If I despair, because for example, I knew that someone was coming to collect something and me there oh my God they come to collect, oh sir, that anguish I felt for not having to covered that need ... And my son also with economic problems, then it also distressed me, not to be able to help him, I cannot help him to take off that problem"

"So I didn't have any money for paying. ... But I think a lot, that house that I have not yet finished paying, that it could be taken away, all that I think, because I have not paid that house. "

"What if I have no job, penniless, because is horrible one without a penny (crying), I needed to buy sometimes, they give me the medicine, but sometimes it ends"

"I sit out there, and after a little while I stand to make food for my children" when I have it, "because when I don't have, I do not beg anyone..."

"ACCESSING HEALTH SERVICES WITH DIFFICULTY"

Access to health services during the crisis occurs at the time of urgency, participants express three aspects that are of great importance. The first, has to do with the lack of money as affirmed that income is insufficient and at the time that is required to consult quickly there is not always availability to cover transportation costs, for that reason there are sometimes delays when consulting in case of emergency:

"Well at the time I had no money to ... to go to the doctor, for ... transport, but I got it, but here in the clinic you do not give, everything has been the clinic."

The second, is the geographical condition that causes difficulty, women living in rural areas move from their homes to the center of attention and then from the municipalities to the city of Cali.

"For half an hour ... they took me in a taxi I think it was. No ... at the farm, until certain place in taxi and from there walking. "

" From there they sent me here, the nurse asked me how I had had it, I was sitting a little while, and then they made me lie down and then the doctor came and told me to take an electro and she said I had to be brought over here in the ambulance from Vijes to here ... "

If you belong to the urban area also they consult the health center first where they are referred to a higher level facility where are finally hospitalized for treatment.

"Then they moved me to XXX. Quickly I was brought here, on the same day.... Because over there they don't have all the resources, not there ... Of course! They brought me in the ambulance ... The doctor told this to my sister in law: "We are going to refer her because here there are not the necessary resources." So the, the, the doctor there said I could not be referred. And again and they sent me back, then they returned and sent me there. (Smile ...) jaIt was like a ride! Then they sent me back XXX, who did not receive me, who did not receive me ... because I needed a form, I do not know which form! Until today I do not know right, but I had no pain, nothing, and thank God. So there I was at the Seguro and on Saturday they brought me here, since then I'm here, day and night. They gave me medicines would not know which... (Makes face of ignorance). Because, why should I know if I'm well-treated Thank God".

"Ahhh, yes!, the hospital. I have gone several times due to chest pain I have gone through the emergency room and they made an electrocardiogram and told me ... you're ok, but this time they referred me. They took me to the hospital, I saw myself there at Carlos Holmes. And there they made one, one, one how's it called? An electro and electro they made. Then the doctor asked for a referral again and then, I was referred to the Departamental".

The third, despite expressing the discomfort above finally, participants recognize that when arriving at health institutions they feel they have been attended immediately and have received the care they require, assessment, diagnostic aids and emergency treatment.

"At the hospital Carlos Carmona ... Then the doctor put me under the tongue a small pill (touched with the index finger the sublingual part), and shot me an injection into the vein. When he returned and I had the pain, I stopped having lunch and stopped and there my God, He said take another pill ... Submit her faster to the emergency room that she has a pain, and the nurse took me and ... there a doctor came and checked me right away. "

"Then the lady asked me: What do you feel?, I said I'm feeling bad, very bad (moves his arms continuously crosscutting) and she told my son: don't fill in any documents, come with her first and a doctor came, I laid down, I was there laying still (spreads her arms on her legs), Dr. made an electro, I heard her saying I had a heart attack."

Category 5. Compliance with treatment,

TREATMENT UNDER MEDICAL SUPERVISION: "I take because I do las send medical"

"I've been 6 months! ... To me he prescribed.... half sublingual pill of isordil nitrate. Until recently that was what calmed me. "Yes, I put it under the tongue. It did not calm me! "

"It's like when I went to the doctor, he sent me pills and I could say that suddenly those pills caused the pain to me. Because those pills made me feel ill and I ... managed to take eight. I left those pills there, and the pain come a go. I do not know, there are those pills at home, I know that the pills are at home. "

TREATMENT WITHOUT PRESCRIPTION: "... I take any pill"

"Sometimes I take any pill. No ... I, I take Dolex. So I didn't go... and there I endured my pain, I took pills, I took ... Ibuprofen ... that was not good for me. "

Their commitment and compliance with the prescription help improve symptoms, avoid complications and hospitalizations.

DISCUSSION

The job responsibility and the income needs make women continue working with discomfort, interpreted this situation as the "minimization" of the problem. These statements are considered as a cognitive strategy according studies about coping, its maximum state cause's disturbance, "seeking instrumental support", considered as a behavioral strategy ⁽²⁷⁾. Even some of the women stop working or change their activities always related to the "role of housewives" confined to domestic service what they call "having to do the house cleaning." Historically in the regulation of working women were assigned the lower skilled jobs, such as domestic work specializing increasingly in attending to the needs of a family and in some cases without financial compensation and in other situations with lower wages ⁽²⁸⁾.

Most women lack of a marital relationship, facing the separation they assume the role of "Single mothers" supplying economic and emotional needs constituting closer ties

with extended families and with a greater participation in decision-making of any kind, with the different family members.

In case of separation it generates a tensional climate, as found in a study where psychological characteristics were analyzed with gender differences in subjects hospitalized at a coronary unit ⁽²⁹⁾.

A retrospective study showed significant increase in relative risk and incidence of angina when people were exposed to anxiety, hyperlipidemia and family psychosocial problems, most of participants thrive in environments where there are social and family conflicts to be resolved. These problems cause them emotional responses perceived as potentially stressful ⁽³⁰⁾; a similar situation was found in a study that was done in previous years in an institution where this research was conducted, the aim was evaluating stressors and social support in elder people with a history of acute myocardial infarction ⁽³¹⁾. But they also state that belonging to a family and community context favors has a positive impact as a source of social support ⁽²⁷⁾.

Regarding the interaction with the environment due to the presence of groups outside the law, violence and insecurity have caused communities to live permanently in fear and uncertainty.

The lack of money to meet basic needs leads housewives to have very strong emotions with intensity, creating internal conflict and stress, forcing them to consult level I health institutions until reaching level III and IV. Besides, administrative requirements and authorizations for hospitalization and treatment studies cause discomfort.

In the Health Promotion Institution (IPS) a study during 2003 and 2004 reports that 38.5% of procedures performed by the specialty of interventional cardiology among angioplasty, and coronary arteriography was performed in women from 30 years of age ⁽³²⁾; at high risk of becoming ill or dying, which can lead to chronic complications causing AMI definitively affecting the quality of life of the person as the psychological and social damage caused by coronary artery disease, as denoting in the case of women participants in the present research.

A response regarding the interaction with environment is denoted, also they say they have a physical discomfort response due to changes in climate that has similarities with the study in Girardot, Colombia ⁽²⁶⁾, whose geographical, climate and temperature are similar to the city of Cali, both riverbank regions.

The study of self-care and adherence in patients with heart failure ⁽³³⁾, makes reference to a better adherence to the pharmacological and non-pharmacological treatment, it requires educational intervention that helps patients overcome the lack of knowledge, to know of medicines, the importance of the disease, diet, maintaining proper weight, recognizing signs and symptoms, exercise, accepting the disease and trust health practitioners.

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Integrated into nursing care the gender equity and equality approach, for the welfare and health care for women considering the role they have played historically. Support networks at community level should have a formality and be integrated with the nursing care, as a source for security, care and living.

Health services should provide more support for women with ischemic heart disease through counselling given by nurses, allowing a more and better therapeutic relationship and where women feel visible and included in health services as part of the human dimension.

CONCLUSIONS

What Lenz et al. described as determining factors in women from Valle del Cauca, are related to a type of physiological history, but what influences the most is the role that women assume and play in their own family dynamics that are the focus and support of the close and extensive relatives, besides not only in the affective role but also in the economical one. In addition the conditions of disadvantage are evidence regarding employment.

The role that women have played historically in our society, in conditions of inequality and submission towards men is still evident and is reflected in the way of life in vulnerable women; concerning the concept of welfare it is suggested to be approached from other research and intervention methodologies to provide in the negotiation and modification of those social and cultural determinants. Taking into account the rigor of applicability and transferability, considering the results of the multicentre study.

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