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Lifestyles and surveillance of sexual and reproductive women's health

Ferreira, M.[a]; Ferreira, S.[b]; Ferreira, N.[c]; Andrade, J.[c]; Chaves, C.[a] & Duarte, J.[a]*

[a]*Instituto Politécnico de Viseu, CI&DETS*
[b]*ACES Dao Lafoes*
[c]*Centro Hospitalar Tondela Viseu*

Abstract

Background: The epidemic increase of diseases is closely related to lifestyle changes. The low adhesion to breast self-examination and cervical cytology hinders prevention and early diagnosis during the asymptomatic state of two silent diseases, with nonspecific symptoms that are a major cause of death by cancer in the Portuguese female population.
Objectives: To analyze the influence of sociodemographic variables and lifestyles in the surveillance of sexual and reproductive health of Portuguese women.
Methods: Quantitative, non-experimental, correlational and cross-sectional study, conducted with a non-probabilistic convenience sample of 522 women aged between 18 and 67 years old, who applied the questionnaires about Breast self-examination, Knowledge about cervical cancer and the Inventory "My Lifestyle" (Ribeiro, 1993.
Results: The average age of women is 38.89 years old. Women aged 31-37 years old (28.6%), Portuguese (99.1%), cohabiting with a partner and / or child (74.0%), with an active employment status (67 5%), residing in urban areas (55.8%) with higher education and attending family planning consultations have better lifestyles, without statistical significance (F = 0.016, p = 0.899).
Conclusions: Healthy behaviors and lifestyles are crucial to good overall health. Adhesion to surveillance of sexual and reproductive women's health is influenced by several factors, including the place of residence, employment status and lifestyles. These variables must be considered by health professionals when planning periodic screenings.

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Keywords: Lifestyles; Sexual Health; Reproductive Health; Womens Health.

* Corresponding author. Tel.: +0-000-000-0000 ; fax: +0-000-000-0000 .
E-mail address: jduarte@essv.ipv.pt

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1. Introduction

Non-hereditary chronic diseases, such as cardiovascular disease, cancer, chronic respiratory disease, diabetes mellitus and mental health disorders, are currently the leading cause of morbidity and mortality in developed societies. These diseases are mainly responsible for cases of disability, often permanent, and loss of quality of life with a very significant expression in the consumption of health services. (DGS 2009)

The increase of oncological diseases leads to a general concern of health professionals about their impact on life quality and the economic effort required to the community. Health professionals should clearly commit themselves with the search for relevant knowledge and the promotion of actions that result in health gains.

Lifestyles are associated with ways of acting, thinking and feeling, covering the various dimensions of the person, the socio-cultural dimension, psycho-affective and biological-behavioral, and also the interactions between each of these dimensions.

Man, through life, undergoes processes of internalization of socio-cultural elements according to the surrounding environment, integrating them in self-personality. Building your lifestyle means understanding the way you manage your life, how it relates with oneself, with others and with the environment (Rapley, 2003). For the author, physical, mental, social, emotional and spiritual health of each individual translates into levels of satisfaction and well-being, the quality of life.

According to Gonçalves and Carvalho (2005), a reflection on the lifestyles based on daily routines is expressed often by dichotomies: west-east; north-south, urban or rural. This socio-geographic organization leads to a social structure that translates a set of preferences and characteristics of a particular condition, which manifests itself in fields and behaviors as varied as food, clothing, housing, home decor, music and dance, leisure time, relationships, languages, consumer habits, health surveillance, policy guidance, education, religion and sexuality.

Recently, we have observed changes in lifestyles of individuals among all ages that enhance risk factors for health, especially regarding consumption patterns that define unhealthy forms of life.

The overall epidemic increase of diseases is closely related to lifestyle changes especially with smoking, physical inactivity and poor diet (World Health Report, 2002).

We shall analyze all the variables that lead to the choice of more or less healthier lifestyles, since behaviors are keys to the construction of a life structure and simultaneously the pillars of health promotion. We can then inquire why individuals adopt behaviors like smoking, eating too much, drinking alcohol or having a diet high in fat and don't monitor their health nor follow screening programs.

Changes in behavior occur when individual realize that current behaviors can lead to unhealthy conditions and the change of habits may reduce the likelihood of illness or disability. As an emerging product of the triad: knowledge (K), values (V) and practice (P) (Clément 2004) lifestyles are assumed as cornerstones of human action and health and can be based on socio-environmental, physical, psychological, social, emotional or connotative systems.

With all the current developments and changes that arise in medical science and society, we find ourselves increasingly faced with the need to educate and enable people of choosing behaviors that prevent diseases and promote health and quality of life. Empowering dynamics are characterized by individual changing processes (self-empowerment) with community implications.

We know now that many of the health problems in adulthood result of chosen behaviors over the years.

Health education can't be limited to the adoption of a particular approach to diseases, nor can it be focused on the informative nature. Educational activities must be integrated in a wider context of health promotion, enabling individuals of making their own decisions and taking responsibility for their health (DGS 2003). Training should allow the development of life skills and awareness that empowers individuals to the decision-making process and to take control over their life and health.

The individual health route is not constant, has specific needs and particularly important moments - critical periods (Health Promoting Health Systems WHO, 2009) which directly influence, positively or negatively, the following stages of life. Intervention in these periods - windows of opportunity - promotes and protects health and can have high relevance (DGS 2012), the person will gradually be transformed and assuming healthier behaviors (Rodrigues et al 2005).

Cancer is a complex and multifactorial disease. According to the 2008 worldwide cancer report of the World Health Organization (WHO), cancer is among the 10 leading causes of death in the world. According to Boyle and

Levin (2008) cancer is one of the diseases with the highest mortality rate in developed countries, especially among individuals aged between 55 and 75 years old. Its strong social impact led to awareness about the importance of early detection and technological evolution (Boyle and Levin, 2008).

The increasing incidence and prevalence of cancer makes it a worldwide public health problem that involves the use of many resources on prevention, treatment and rehabilitation. It is essential to establish appropriate measures to avoid the problem. Health promotion, disease prevention, early detection and screening are among the most effective strategies in the fight against cancer (Franco and Rohan, 2002).

According to the National Statistics Institute (INE), cancer is the second leading cause of death in Portugal, right after cardiovascular disease, similarly to what happens in other developed countries.

According to Ferlay et al (2007), breast cancer is a disease whose incidence is higher in females with more than 10% of new worldwide cases diagnosed each year and 410 000 deaths (O'Anderson et al ., 2007). In 2006 in Europe, according Ferlay, breast cancer represented 28.9% of all new cases of cancer.

In Portugal 4300 new cases of breast cancer are registered per year, more than 11 new cases per day (3 more in the center region), 75% of cases appear after the age of 50 and it is estimated that 1 in each 12 women will develop breast cancer during her life. About 4 to 5 women die daily but if the disease is detected early the survival rate can reach 95% in the first five years (ARS, 2006).

Indeed, according to Fernandes, Perelman and Mateus (2009) breast cancer is the leading cause of death for women aged 35-54 years old and accounts for 2.9% of all deaths in Portugal.

According to the Portuguese Department for general health in their report (2004) entitled "The risk of dying in Portugal", there were 1443 deaths from breast cancer, of which the largest number was recorded in the region of Lisbon and Tagus Valley with 582 deaths while in the central region 319 deaths were registered.

The causes of this type of cancer are unknown, but appear to include various environmental, psychological, endocrine and genetic factors. Accordingly, no single factor or combined factors can predict the onset of breast cancer nor explain its etiology.

According to Vogel, 2000, cit in Smeltzer and Bare (2005), 60% of women diagnosed with breast cancer do not show any of the worldwide known risk factors, so all women are considered at risk of developing breast cancer and should be covered by screening programs, allowing early diagnosis and timely treatment.

The focus of attention of this study are women and their health practices, including lifestyles and accession to screening programs for breast and cervical cancer.

2. Methods

We conceptualized a quantitative, descriptive, non-experimental, correlational and cross-sectional study. We considered adhesion to breast and cervical cancer surveillance as our dependent variable and sociodemographic background variables, recommendation for breast self-examination, knowledge about cervical cancer, health beliefs about breast self-examination and cervical cancer and lifestyles as independent variables, as expressed in the schematic representation of Figure 1, which implies the research’s conceptual design.

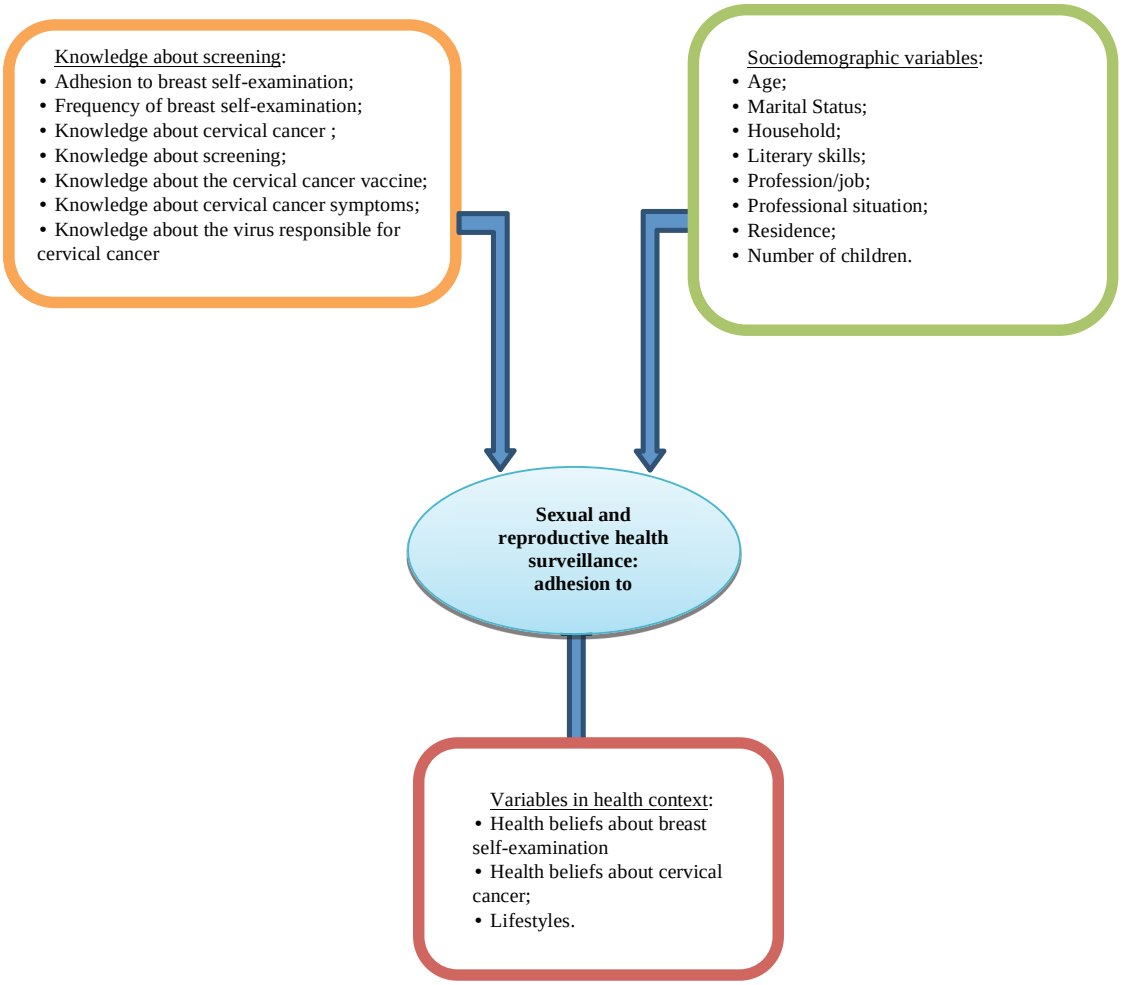

Figure 1 - Conceptual design

We used a non-probabilistic convenient sample with 522 women with a minimum age of 18 years old and a maximum of 67 years old, attending family planning counseling and the woman health appointments of the National Health System.

Data collection has been processed using a self-administered measurement instrument, which incorporates gauged and validated rating scales for the Portuguese population with reasonable internal consistency as well as a sociodemographic record specifically built for the purpose of this study. The data collection instrument is divided into 4 sections: recommendation and adhesion to breast self-examination, health beliefs scale about breast cancer and breast self-examination (Champion and Scott 1997), Knowledge about cervical cancer and screening and a range of health beliefs about cervical cancer (Patrão and Leal 2002).

The period of data collection took place between March and August 2012. Initially the measuring instrument protocol was submitted for approval of the ACES' authorities and later informed consents were obtained from all participants. Statistical analysis was performed using the Statistical Package for the Social Sciences® (SPSS - version 20.0), which enabled the preparation of descriptive and inferential statistics.

3. Results and Discussions

Women had an average age of 38.89 years old ± 11.84 SD. The most prevalent age group is under 30 years old (25.7%). The vast majority of women are married or cohabiting with partners (62.8%) and the majority is from 38 to 47 years old. The highest percentage of single women is 30 years old or less.

Almost all women are Portuguese (97.7%). About three quarters of women cohabite with their partner and / or child and the highest percentage is from 38 to 47 years old. Only 27.2% of women live with other family elements (parents or siblings). The majority of women completed the 2nd studying cycle (56.1%) and 38.5% completed high school. Most of the graduated women belong to the 31-37 age group (43.9%). Regarding the profession/job, most women (38.9%) is part of the group II, corresponding to unskilled farmers and workers, and most are from 38 to 47 years old (46%). Housewives, unemployed and students are mostly younger (45.5%) while those belonging to senior management and technical services (group I) (39.4%) are between 31 and 37 years old. We found that 65.9% of the sample is actively employed and aged between 38 and 47 years old. 55% of women living in urban areas have from 48 to 67 years old.

We found that about a quarter to half of women aged between 38 to 47 years have two children, while the majority of women under 30 years old does not have children (73.9%).

When drawing the profile of women attending sexual and reproductive health monitoring appointments, we found women aged between 31 and 37 years old (26.8%), married (66.6%), Portuguese (97.6%), cohabiting with a partner and / or child (76.5%) that completed high school (36.5%), working in a job from the group of farmers and unskilled workers (39.6%), actively employed (67.5%) living in urban areas (56.4%) and with two children (34.7%). These results go against those found by Ogden (2004), Patrão (2002) and Areias (2011).

About half of the women who answered the questionnaire perform breast self-examination at least once a month. Women who perform breast self-examination more frequently are those aged above 48 years old (30.2%), married (66.0%), Portuguese (96.0%), living with partner and / or children (75.3%), that completed high school (35.9%), have a job from the group of farmers and unskilled workers (37.3%) are actively employed (65.8 %), live mostly in urban areas (57.7%) and have at least two children (33%). According to Harrison et al. (1997), the increased risk of developing breast cancer is expressed after the age of 50, being higher after 75, on the other hand, Otto (2000) tells us that breast cancer is the leading cause of death in women between 35 and 54 years old and Cantara (2002) stated that although the incidence of breast cancer increases with age, most women with breast cancer are between 40 and 50 years old. Breast cancer is considered the leading cause of death in women over 55 years old, accounting for a considerable percentage of deaths among this sex (Serrano and Pires, 2004).

The prevalence of women attending sexual and reproductive health surveillance appointments at the health center / gynecologist and perform breast self-examination is 80.7%, with statistical differences between the groups.

We tried, however, to understand in what extent performing breast self-examination changes beliefs about breast cancer. We found that women who frequently perform breast self-examination have lower perceived risk of developing breast cancer (vulnerability), less difficulties and barriers associated with the breast self-examination (obstacles), are more capable of performing breast self-examination correctly (efficiency) and have better knowledge about the advantages of performing breast self-examination (benefits) with statistical significance for the overall value of the scale, obstacles, benefits and efficiency. Our data meets the findings of Silva, Paiva and Vasconcelos (2005).

On the other hand, Reis and Teixeira (2000) found that beliefs about vulnerability and benefits were the most valued for the entire sample, while in our study the most valued beliefs were obstacles and efficiency, similarly to Silva, Paiva and Vasconcelos (2005).

In order to understand the relationship between adopted behaviors and the knowledge women have about cervical cancer, several questions were made. Regarding knowledge about cervical cancer, we found that 98.9% of women are familiar with the subject. Most women (56.5%) obtains information about cervical cancer through the media / internet, 50.2% from their USF / UCSP (Familiar units and health centers) and 44.3% of women get information from the gynecologist. 94.1% of women stated that cervical cancer can lead to death when later diagnosed.

When confronted with their doubts, women express they would like to be informed about the signs and symptoms of cervical cancer (60.3%), forms of prevention (47.3%) causes of cervical cancer (42.5%) and diagnostic tests (26.2%). The Portuguese Ministry of Health in the national plan for prevention and control of oncological diseases 2007/2010, states that awareness is a priority and that we all should be concentrated on prevention and educative

activities regarding risk factors.

Regarding the knowledge about cervical cancer surveillance, 69.5% of women follow the screening program and the majority (43.9%) thinks it should be done once a year and after the beginning of sexual activity (46, 6%). It is important to highlight that 30.8% of women started the screening program before they initiated their sexual activity while 5% had the first cytology done late in menopause. Most women know the screening test for cervical cancer (83.3%) and states that the responsible virus can be diagnosed by cytology.

We found that 91% recognize vaccination as a way to prevent cervical cancer and 64% of women think it should be carried out prior to the beginning of sexual activity. We obtained similar results to Areias (2011) and better than Malheiro (2009). The increased dissemination of information about the vaccine and its inclusion in the national vaccination plan may explain these results.

Family history of cervical cancer is the most mentioned risk factor (71.3%) followed by multiple sexual partners (55.6%), age (27.6%) and smoking habits (20.1%), also identical results to the ones found by Areias (2011).

As to the knowledge about symptoms, 77.4% of women understand that cervical cancer has symptoms and 22.6% think this condition is asymptomatic, this may be due to the fact that the signals and symptoms of cervical cancer can be confused with an infection and also because cervical cancer can show no signs or symptoms until it reaches an advanced stage (Silva, 2010). For the majority (67.2%) the main symptom is unusual bleeding, followed by urinary tract infection (14.9%), absence of menstruation (13.8%) and burning sensation (12.8%).

As to the knowledge about the responsible virus, 74.7% of women believe that cervical cancer is caused by a virus and 64.8% identified it as the human papilloma virus (HPV). However, 4.6% of women still consider AIDS virus, 2.9% hepatitis and 2.7% the herpes virus as being responsible for cervical cancer.

As for the global knowledge about cervical cancer the highest percentage of those who attend appointments revealed good knowledge about cervical cancer (49.8%). Among those who did not attend specific medical appointments and therefore do not follow surveillance programs, we found 65.7% of women have weak knowledge. The differences are statistically significant between the group of women with good knowledge about cervical cancer that follow surveillance programs and the group of women with weak knowledge about cervical cancer that don't go to specific medical appointments.

We can also infer that global knowledge about cervical cancer affects adhesion to sexual and reproductive health surveillance. These results are more promising than those found by Areias (2011).

Low adhesion to screening tests can have serious consequences and lead to late diagnosis and secondary complications. Breast self-examination and cervix cytology, performed according to the directives of the General Health Directorate enable prevention and early diagnosis, often at an asymptomatic stage of the disease.

Our study also revealed that 45.6% of the sample was classified as having very appropriate beliefs about breast cancer and breast self-examination while 37.9% of women have suitable beliefs about breast cancer and breast self-examination and 16 5% have reasonable beliefs.

The bivariate analysis established with the socio-demographic and professional variables found that women from 31 to 37 years old (32.5%), married (65.1%) and Portuguese (100%) had higher percentages of reasonable beliefs about breast self-examination and breast cancer. Women who live with their partner and / or child (75.0%), graduated (45.5%), with professions/jobs from group I corresponding to the senior management and technical services (44.1%), actively employed (69.1%), living in urban areas (61.4%) and with two children (31.8%) have the highest percentage of very appropriate beliefs about breast cancer and breast self-examination.

As for the relationship between adhesion to sexual and reproductive health surveillance and beliefs about cervical cancer, we noted that the highest percentage of women following surveillance appointments is found among women with little appropriate beliefs about Cervical Cancer (43.1%). Among those who do not attend appointments and therefore do not adhere to surveillance we found 38.6% of women with very appropriate beliefs about cervical cancer. The differences between groups were not statistically significant.

To find out if there was a correlation between lifestyles and adhesion to sexual and reproductive health surveillance we performed a discriminant function analysis using the input method. The independent variables that entered the model were the frequency with which the individual implements certain actions, the attitude towards certain actions (global lifestyles) and the dependent variable of sexual and reproductive health monitoring in the health center and / or gynecologist. The Box's M test tells us that the dispersions observed between the groups are not statistically significant (Table 1).

Groups	Determinants	Box's M	F	p
Attending women's health medical appointments	9.268	6.668	2.199	0.086
Not attending women's health medical appointments	8.982			
Between groups	9.243			

TABLE 1 - Dispersion among the groups to the scale "my lifestyle"

We verified through the Wilk's Lambda that there are no differences between the means of variables and lifestyles. We ended the analysis between lifestyles and our dependent variable as presented in table 2. The values obtained show that the percentage of correct classifications given by maximum likelihood à priori is 86.6% (maximum chance criterion) and the percentage of randomly obtained correct classifications is 86.6% (proportional chance criterion) similarly to correct classifications, which may enable the results obtained.

	Wilks' Lambda	F	Sig.
Frequency	0.999	0.591	0.442
Attitudes	0.999	0.261	0.610
Global lifestyle	1.000	0.016	0.899

TABLE 2 - Average equality test between the subscales and the global scale of my lifestyle

4. Conclusion

A link between breast oncological disease and some risk factors can be established. These risk factors may still be classified as genetic, hormonal, environmental or related with habits and lifestyles. According to (Ricks, 2005) there are several known risk factors including: family history of breast cancer, aging, exposure to carcinogens, nulliparity and late motherhood (first child after the age of 30). A long menstrual life, early menarche or delayed menopause, also increases the risk of cancer. Obesity, a diet rich in fats, alcohol abuse and the use of medications containing estrogen may increase the risk of cancer, which makes evident the need to develop healthy habits among women. Healthy behaviors and lifestyles are the key to a globally good health.

In our study, adhesion to women's sexual and reproductive health surveillance is influenced by several factors such as the place of residence, employment status and lifestyles. These variables must be considered by health professionals while planning periodic screening appointments.

Greater benefits understood by woman lead to a higher probability of frequently performing breast self-examination and cervix cytology, promoting their sexual and reproductive health, developing their knowledge about breast and cervical cancer and enabling women to fight this scourge, often silent, but important cause of death among the Portuguese female population (Ferreira et al 2014).

Educating and promoting sexual and reproductive health should emphasize not only the importance of informed choices and the advantages of empowered women with responsible attitudes towards health, but also the importance of creating a favorable structural environment for healthy lifestyles promotion.

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