SOCIODEMOGRAPHIC CHARACTERISTICS AND IMPORTANT FACTORS FOR HEALTH MAINTENANCE IN WOMEN

Características sociodemográficas e fatores importantes para a manutenção da saúde em mulheres

Características sociodemograficas y factores importantes para el mantenimiento de la salud de mujeres

Original Article

Márcia Cristina Sales[1]
Ana Carolina Dantas Rocha[2]
Dixis Figueroa Pedraza[3]

ABSTRACT

Objective: To investigate important factors for health maintenance and the socioeconomic and demographic characteristics of women users of Basic Health Units. **Methods***:* Observational, cross-sectional, and analytical study, carried out in 2011, involving 204 women seen in 26 units of the city of Queimadas, Paraíba. Information regarding demographic (housing location, skin colour, age, and marital status) and socioeconomic characteristics (educational level and assistance by the 'Bolsa Família' conditional cash transfer program), and life habits (diet, smoking, medical consultation, sedentarism, alcohol intake, and weight and stress control) was obtained by questionnaire, and then applied descriptive statistics and prevalence ratio. **Results:** The participants had mean age of 28.22 years (SD=6.49). The majority lived in rural areas (n=126; 61.76%), declared being able to read or write (n=184; 90.2%) and receiving the Bolsa Família grant (n=153; 75.0%). The most frequently cited features for health maintenance were healthy diet (n=126; 61.8%), not smoking (n=21; 10.3%), and regular medical consultation (n=19; 9.3%). The socioeconomic and demographic variables showed no significant statistical associations with the important features for health maintenance. **Conclusion:** The studied population recognizes the healthy diet, not smoking, and regular medical consultation as the most important features for health maintenance.

Descriptors: Health Knowledge; Attitudes; Practice; Life Style; Women's Health.

RESUMO

Objetivo: *Investigar fatores importantes para a manutenção da saúde e as características socioeconômicas e demográficas de mulheres usuárias de Unidades Básicas de Saúde.* **Métodos:** *Estudo observacional, transversal e analítico, realizado em 2011, envolvendo 204 mulheres assistidas em 16 unidades do município de Queimadas, Paraíba. Obtiveram-se informações referentes às características demográficas (local de moradia, cor da pele, idade e situação conjugal), socioeconômicas (nível de escolaridade e recebimento do Bolsa Família), e hábitos de vida (alimentação, tabagismo, consulta médica, sedentarismo, ingestão de bebidas alcoólicas, controle do peso e do estresse) por meio de questionário, ao qual aplicou-se estatística descritiva e razão de prevalência.* **Resultados:** *As participantes apresentaram idade média de 28,22 anos (DP=6,49). A maioria residia na zona rural (n=126; 61,76%), declarou saber ler ou escrever (n=184; 90,2%) e receber o benefício Bolsa Família (n=153; 75,0%). Os fatores mais importantes para a manutenção da saúde foram a alimentação saudável (n=126; 61,8%), o não tabagismo (n=21; 10,3%) e a consulta médica regular (n=19; 9,3%). As variáveis socioeconômicas e demográficas não apresentaram associações estatisticas significativas com os fatores importantes para manutenção da saúde.* **Conclusão:** *A população estudada reconhece a alimentação saudável, o não tabagismo e as consultas médicas regulares como os fatores mais importantes para a manutenção da saúde.*

Descritores: *Conhecimentos; Atitudes e Prática em Saúde; Estilo de Vida; Saúde da Mulher.*

1) Federal University of Rio Grande do Norte (*Universidade Federal do Rio Grande do Norte - UFRN*) - Natal (RN) - Brazil

2) Federal University of Ceará (*Universidade Federal do Ceará - UFC*) - Fortaleza (CE) - Brazil

3) State University of Paraíba (*Universidade Federal da Paraíba - UFP*) - Campina Grande (PB) - Brazil

Received on: *10/30//2013*
Revised on: *07/23/2014*
Accepted on: *10/21/2014*

RESUMEN

Objetivo: *Investigar los factores importantes para el mantenimiento de la salud y las características socioeconómicas y demográficas de mujeres usuárias de Unidades Básicas de Salud.* **Métodos:** *Estudio observacional, transversal y analítico realizado en 2011 con 204 mujeres assistidas en 16 unidades del município de Queimadas, Paraíba. Se obtuvieron informaciones sobre las caracterisiticas demográficas (lugar de vivenda, color de la piel, edad, situación conyugal), socioeconómicas (nível de escolaridade y recibimiento de Bolsa Familia) y hábitos de vida (alimentación, tabaco, consulta medica, sedentarismo, ingesta de bebidas alcohólicas, control de pesoy del estrés) a traves de cuestionario. Se aplico estadística descriptiva y razón de prevalencia.* **Resultados:** *Las participantes presentaron edad media de 28,22 años (SD=6,49). La mayoría vivía en la zona rural (n=126; 61,76%), ha declarado saber leer o escribir (n=184; 90,2%) y recibir el beneficio Bolsa Familia (n=153; 75,0%). Los factores más importantes para el mantenimiento de la salud fueron la alimentación saludable (n=126; 61,8%), la no utilización del tabaco (n=21; 10,3%) y la consulta medica regular (n=19; 9,3%). Las variables socieconómicas y demográficas no presentaron asociaciones estadísticas significativas con los factores importantes para el mantenimiento de la salud.* **Conclusión:** *La población investigada reconoce la alimentación saludable, la no utilización del tabaco y las consultas medicas regulares como los factores más importantes para el mantenimiento de la salud.*

Descriptores: *Conocimientos; Actitudes y Prácticas en Salud; Estilo de Vida; Salud de la mujer.*

INTRODUCTION

Personal habits and lifestyle exert great impact on the individuals' health status. Even though genetics, the environment and healthcare play an important role in how and how much one lives, evidence shows that lifestyle is the differentiating factor for health and quality of life in the contemporary world[1]. Lifestyle comprises the general way of life, based on the interaction between living conditions and individual conduct actions[2].

The World Health Organization, through the Ottawa Charter, highlighted the importance of encouraging people's greater control of their health, considering the community qualification process to act in the improvement of their quality of life. It thus denotes the need to perform health education actions [3,4].

In Brazil, the Primary Care Policy seeks the involvement of all government levels in actions that enable permanent health education. From this perspective, the importance of primary care lies in its work with the population towards the adoption of healthy lifestyle habits, which include physical activity practice, nutritional guidelines, incentive to abandonment of harmful habits such as smoking and alcoholism, obesity-related care, and access to health services[5].

Healthcare, however, requires a broader view of the subjects' living conditions, considering the social context in which they live, as well as the individual characteristics of the human being[6]. Therefore, the importance of gender analysis in the context of health actions stands out. Just as different populations are exposed to different risk factors to health, in accordance with the social organization of gender relations and aspects of biological nature, they are also exposed to diverse patterns of illness and death[7].

Women represent the majority of the Brazilian population (50.77%) and the main users of the Unified Health System[7]. They live longer than men, however, get sick more often, and are more vulnerable to certain diseases[7,8]. In Brazil, the main causes of death among female population are the cardiovascular diseases; neoplasms, especially breast, lung and cervical cancer; diseases of the respiratory system; and endocrine, nutritional and metabolic diseases, with prominence of diabetes[7].

Even though the knowledge about risk and protective factors for these diseases is quite widespread, little is known about the women's perception about the degree of importance given to them. This understanding represents an important aspect in the planning of care and health education practices directed at the female population, enabling greater focus on factors considered of minor importante, which yet significantly influence the population's health status.

The present study aims to investigate important factors for health maintenance and the socioeconomic and demographic characteristics of women users of the Basic Health Units.

METHODS

Observational, cross-sectional, and analytical study, developed in the period from July to August 2011, in 16 Family Basic Health Units (FHU) of the municipality of Queimadas - Paraíba - Brazil, which are responsible for providing prenatal care to low-risk pregnant women.

The health system of Queimadas municipality consists of 16 FBHU, 11 of them in the rural area and five in urban area, a Psychosocial Care Center (*Centro de Atenção Psicossocial - CAPS*); a Support Center for Family Health (*Núcleo de Apoio à Sáude da Família - NASF*); one Health Center, where dental care and biochemical-laboratory testing services are pprovided; and a Joint Unit, which provides support to the health services network.

The population eligible for the study comprised all women who gave birth during the year of 2009 and lived

in the city at the time of data collection. To quantify the total of mothers who had a child in 2009, the Certificates of Live Birth (CLB) available at the Municipal Health Secretariat were considered (n=407), whose information was complemented by the active pursuit of births (n=43) with the community health workers (CHW) and nurses. Considering the address in the CLB, a mapping of mothers was carried out by the FHU, according to the coverage area of each unit. The identification of those who were no longer living in Queimadas (n=27) was verified by key informants (nurses, CHW, and community leaders).

Invitation letters were sent, through the CHW, to the mothers eligible for the study (n=423), with the date and time when they should attend the FHU. The mothers were also asked to take with them, at that time, the Child Card/ Child Health Handbook (CC/CHH). Another meeting was scheduled, in each of the FHU, with mothers who did not attend at the first attempt - and if even so the mother did not attend, phone contact and/or household visit was tried. Mothers with whom it was not feasible to contact (n=120) were considered losses.

The exclusion criteria were: mothers who did not perform any prenatal consultation at any of the municipal FHU (n=43); mothers who became pregnant again after the child born in 2009 (n=40); mothers aged under 18 years (n=1); mothers who had children with serious congenital malformations (n=2) and twin births (n=1); mothers of deceased children (n=3). This information was provided by nurses and/or collected from official documents (Registry books, medical records, SIAB files). Nine mothers refused to participate, totalling 204 women investigated in this study.

Information was collected at the FHU and/or in the household, by professionals and healthcare students properly trained and supervised. An instruction manual was developed, aiming to guide and standardize the questionnaire filling and data collection, and training was implemented with the interviewers for consideration of the data collection instrument and inclusion of suggested adjustments, based on discussions and evaluations. The pilot study was done at the Palmeira Health Center, in Campina Grande. In a second stage, the interviewers discussed the difficulties encountered, the moment when new adaptations were made in the questionnaire, eventually resulting in the final model that was applied.

The collection instrument used in this research consisted of a questionnaire addressed to women, with closed questions, containing demographic and socioeconomic information, and information related to lifestyle habits. The interviewees were instructed to list, in order of increasing importance, three measures that, in their opinion, were considered most relevant to maintaining health. In addition to the questionnaire, the fieldwork control registry was used to record accepts, denials, exclusions and losses.

As demographic variables, they investigated the place of residence, skin colour, age and marital status. Socioeconomic variables evaluated encompassed the ability to read and write, years of schooling, and receiving the Family Grant Program (*Bolsa Família*) benefit. As for variables related to lifestyle habits, the following ones were collected: keeping healthy eating, avoiding animal fat; not smoking; consulting the doctor regularly; exercising regularly; not drinking alcohol in excess; maintaining the ideal weight; and controlling or avoiding stress.

Statistical analysis was done with the aid of the Epi-Info v.6.04b and R v2.10.0 softwares. The measures related to health habits reported by the respondents as the most important for health maintenance were considered as dependent variables. And, as independent variables, the demographic and socieconomic variables.

By means of descriptive statistics (single frequency), the variables were presented for the characterization of the population. As for the analysis of qualitative variables, an approach with univariate analysis was used for each of the independent variables and the dependent variable. The strength of association between the independent variables and the dependent one was expressed as prevalence ratio calculated by Poisson regression with 95% confidence interval. The conclusions were based on a significance level of 5%.

Data collection occurred after the study approval by the Ethics Committee of the State University of Paraíba (no. 423696) and signing of the consent form by the participants, according to Resolution 466/12 of the National Health Council.

RESULTS

With regard to the sociodemographic characteristics, most of the interviewed women lived in the countryside (n=126; 61.76%) presented brown-coloured skin (n=146; 71.57%), and were in the age group of 20 to 34 years (n=156; 76.5%), with mean age of 28.22 years (standard deviation=6.49). As for schooling, 184 (90.2%) women reported knowing how to read or write, and 102 (50.0%) respondents had between 5 and 11 years of study. There was a predominance of women who lived with a partner (n=165; 80.9%) and received the Bolsa Família benefit (n=153; 75.0%) (Table I).

When asked about the most important factors for maintenance of good health, 126 (61.8%) women pointed keeping a healthy diet and avoiding to eat much animal fat; 21 (10.3%), not smoking; 19 (9.3%), consulting the doctor regularly; 15 (7.4%), exercising regularly; 11 (5.4%), not

drinking alcohol in excess; 6 (2.9%), maintaining the ideal weight; and 6 (2.9%), controlling or avoiding stress. (Table II).

The variables 'maintain a healthy diet', 'not smoking', 'consult doctor regularly' 'perform physical exercise regularly,' 'not drinking alcohol in excess' and 'control or

Table I - Sociodemographic characteristics of 204 women resident in the coverage areas of the Basic Health Units. Queimadas-PB, 2011.

Variable	n	%
Place of residence		
Urban zone	78	38.24
Rural zona	126	61.76
Skin colour		
White	58	28.43
Brown	146	71.57
Age		
≤ 19 years	12	5.88
20-34 years	156	76.47
≥ 35 years	36	17.65
Able to read and write		
Yes	184	90.20
No	20	9.80
Years of schooling		
< 5 years	41	20.10
5-11 years	102	50.00
≥ 12 years	61	29.90
Marital status		
With partner	165	80.88
Without partner	39	19.12
Bolsa Família benefit		
Yes	153	75.00
No	51	25.00

Table II - Most important factors for health maintenance among women resident in the coverage areas of the Basic Health Units. Queimadas-PB, 2011.

Variable	n	%
Healthy diet	126	61.8
Not smoking	21	10.3
Consulting the doctor regularly	19	9.3
Performing physical exercise regularly	15	7.4
Not drinking alcohol in excess	11	5.4
Maintain the ideal weight	6	2.9
Control or avoid stress	6	2.9

avoid stress' were most frequently cited by the women living in the countryside, brown-coloured, aged 20-34 years, who claimed being able to read and write, with 5-11 years of education, who lived with their partner and received the Bolsa Família benefit. (Tables III and IV).

The variable 'maintain the ideal weight' was most frequently cited by women under 5 years of study, and achieved the same degree of importance for the residents of the rural and urban areas, with similar distribution to the other dependent variables in relation to other sociodemographic factors. (Table IV).

It is noteworthy, however, the abscense of statistically significant associations between the socioeconomic variables and the important factors for health maintenance. (Tables III and IV).

Table III - Distribution of the women percentage according to the three factors reported as the most important for health maintenance and the sociodemographic characteristics. Queimadas-PB, 2011.

Variable	Healthy diet		Not smoking		Consult the doctor	
	%	PR (CI95%)	%	PR (CI95%)	%	PR (CI95%)
Place of residence						
Urban zone	42.86	1.00	33.33	1.00	31.58	1.00
Rural zona	57.14	1.39 (0.87-2.29)	66.67	0.98 (0.73-1.32)	68.42	0.97 (0.72-1.31)
Skin colour						
White	28.80	1.00	42.86	1.00	21.05	1.00
Brown	71.20	1.02 (0.63-1.70)	57.14	1.09 (0.79-1.52)	78.95	0.96 (0.71-1.33)
Age						
≤ 19 years	4.76	1.00	19.05	1.00	0.00	1.00
20-34 years	76.19	0.77 (0.36-1.99)	57.14	1.38 (0.73-3.08)	89.47	0.89 (0.52-1.70)
≥ 35 years	19.05	0.67 (0.26-1.92)	23.81	1.29 (0.62-3.02)	10.53	0.94 (0.50-1.90)
Able to read and write						
Yes	91.27	1.00	90.48	1.00	89.47	1.00
No	8.73	1.20 (0.56-2.28)	9.52	1.00 (0.60-1.59)	10.53	0.99 (0.59-1.57)
Years of schooling						
< 5 years	17.46	1.00	28.57	1.00	15.79	1.00
5-11 years	49.21	0.85 (0.50-1.49)	42.86	1.07 (0.73-1.60)	68.42	0.94 (0.65-1.39)
≥ 12 years	33.33	0.67 (0.35-1.28)	28.57	1.06 (0.69-1.63)	15.79	1.03 (0.68-1.56)
Marital status						
With partner	85.71	1.00	66.67	1.00	78.95	1.00
Without partner	14.29	1.56 (0.92-2.53)	33.33	0.90 (0.60-1.29)	21.05	0.99 (0.67-1.41)
Bolsa Família benefit						
Yes	71.43	1.00	76.19	1.00	89.47	1.00
No	28.57	0.71 (0.39-1.22)	23.81	1.01 (0.71-1.39)	10.53	1.08 (0.77-1.49)

PR: Prevalence ratio; CI: Confidence interval.

Table IV – Distribution of the women percentage according to the other factors reported as important for health maintenance and the sociodemographic characteristics. Queimadas-PB, 2011.

Variable	Exercise regularly		Not drinking alcohol		Keep ideal weight		Control/avoid stress	
	%	PR (CI95%)	%	PR (CI95%)	%	PR (CI95%)	%	PR (CI95%)
Place of residence								
Urban zone	33.33	1.00	27.27	1.00	50.00	1.00	0.00	1.00
Rural zona	66.67	0.98 (0.74-1.32)	72.73	0.97 (0.73-1.31)	50.00	1.02 (0.76-0.36)	100.00	0.95 (0.72-1.27)
Skin colour								
White	20.00	1.00	36.36	1.00	0.00	1.00	33.33	1.00
Brown	80.00	0.97 (0.71-1.33)	63.64	1.02 (0.75-1.41)	100.00	0.96 (0.71-1.31)	66.67	1.01 (0.74-1.38)
Age								
≤ 19 years	0.00	1.00	9.09	1.00	16.67	1.00	0.00	1.00
20-34 years	86.67	0.92 (0.53-1.74)	63.64	1.04 (0.59-2.04)	83.33	1.06 (0.60-2.07)	100.00	0.96 (0.56-1.83)
≥ 35 years	13.33	0.94 (0.50-1.90)	27.27	1.00 (0.52-2.07)	0.00	1.09 (0.57-2.25)	0.00	1.00 (0.54-2.00)
Able to read and write								
Yes	80.00	1.00	90.91	1.00	100.00	1.00	83.33	1.00
No	20.00	0.91 (0.53-1.45)	9.09	1.00 (0.61-1.57)	0.00	1.03 (0.63-1.60)	16.67	0.98 (0.59-1.52)
Years of schooling								
< 5 years	20.00	1.00	18.18	1.00	50.00	1.00	33.33	1.00
5-11 years	46.67	1.00 (0.70-1.48)	63.64	0.98 (0.68-1.44)	16.67	1.07 (0.74-1.57)	50.00	1.02 (0.71-1.49)
≥ 12 years	33.33	0.99 (0.66-1.51)	18.18	1.02 (0.68-1.53)	33.33	1.04 (0.70-1.58)	16.67	1.03 (0.69-1.56)
Marital status								
With partner	93.33	1.00	54.55	1.00	66.67	1.00	66.67	1.00
Without partner	6.67	1.06 (0.74-1.50)	45.45	0.90 (0.61-1.29)	33.33	0.97 (0.67-1.37)	33.33	0.97 (0.67-1.37)
Bolsa Família benefit								
Yes	86.67	1.00	72.73	1.00	50.00	1.00	100.00	1.00
No	13.33	1.05 (0.75-1.44)	27.27	0.99 (0.71-1.37)	50.00	0.96 (0.69-1.32)	0.00	1.04 (0.75-1.42)

PR: Prevalence ratio; CI: Confidence interval.

DISCUSSION

Lifestyle is a determining element of health promotion. There are lifestyle factors that can negatively affect health, over which one can have control, like smoking, alcohol, and stress. Nonetheless, there are positive factors, such as diet, physical activity and preventive behavior, which, if properly administered, contribute to the prevention and control of various diseases[1,9]. In healthcare for women, knowing the degree of importance attached to these factors can be useful in planning health actions that encourage the adoption of healthy lifestyles, with greater focus on the health measures less prioritized by the population.

In the present study, the majority of women recognized diet as a key measure for the maintenance of health. These findings corroborate results obtained in a study for the assessment of self-care actions in a group of women in Rio Grande do Sul, which revealed the importance attached by the interviewees to the adoption of healthy dietary practices, such as reducing fat intake and the consumption of fruits and vegetables[10]. Such findings may be related to the fact that, in virtually all cultures, food has always been related to health, not just because its abundance or scarcity bring into question the human survival, but also because the medical approach about healthy eating habits has always exerted a significant influence on human attitude towards food[11].

The indication of not smoking was classified in second place among the priority measures for the maintenance of health in this study. According to a national survey [12] conducted by the National Cancer Institute and the Pan-American Health Organization, about 96% of the respondents believed that smoking causes serious health damages. Moreover, of all people aged ≥ 15 years who smoked, 45.6% had tried to quit smoking in the last 12 months, and the women had tried to quit more often than men (49.5% versus 43.0%), what suggests the female population's concern about the smoking habit and health. These data also converge with the reduction in the prevalence of smokers in Brazil, more frequent among women[13]. Despite the success associated to the smoking prevention and control actions, including those of an educational nature[14], there is still lack of studies analysing gender issues and tobacco[13], which could found the actions aiming to maximize the impacts.

The indication to consult the doctor regularly ranked third among the most cited health measures in the current investigation. Such occurrence may be related to the fact that the sample is composed of individuals assisted by the FHU, which enables counseling by health professionals on the importance of regular medical consultations[5]. Additionally, women of childbearing age, which constitute part of this study, are considered to tend to consult doctors more often, due to gynecological and obstetric factors[15].

The regular practice of physical exercise obtained the fourth place among the most frequently measures cited in the current study. Literature data, in accordance with the results of the interviewees, showed that physical activity is not a priority for most women, being observed high prevalence of physical inactivity in studies conducted in Bahia (72.5%)[16] and Santa Catarina (56.9%)[17]. This is a worrysome data, inasmuch as regular physical activity represents a factor of primary prevention and therapeutic support for various health conditions, such as obesity, diabetes, hypertension, coronary artery disease, stress, and depression[2,18,19].

The habit of not drinking alcohol in excess was the fourth most prevalent measure in this study. A study conducted in 2004 with 8,579 individuals in 107 Brazilian cities, pointed out a high number of women who use alcohol, the largest proportion being observed in the age group of 18-34 years[20]. This result converges with the reduced importance given to the habit of drinking by the studied women, also indicating that the age of greatest vulnerability corresponds to the majority of the study population. Latest results show plausibility to indicate that alcohol consumption use is increasing among the female population. The importance of these results is evident when considering the consequences of alcohol use, most pronounced in women than in men. Physical diseases affect women at a level of exposure to alcohol lower than men, with greater impairment of the cognitive and motor functions. Furthermomre, excessive consumption of alcohol makes women more vulnerable to the occurrence of sexual abuse[21].

Regarding the maintenance of ideal weight and the stress management, these were the least prioritized measures to maintain health among the women investigated in this research. Excess weight is a risk factor for the occurrence of chronic diseases like diabetes, heart disease and certain cancers[18]. According to the Brazilian Institute of Geography and Statistics[22], a steady increase in overweight and obesity was observed in the female population aged 20 years or more, between the 1974-75 period and 2009. Overweight raised from 28.7% in 1974-75 to 48.0% in 2008-09, while obesity has doubled in this period, being observed an increase from 8% to 16.9%. Given the above, and considering that the results of this study, with regard to the low importance attached to the maintenance of ideal weight as a health measure, are similar to those observed among users of basic units of 41 municipalities with more than 100,000 inhabitants in South and Northeast regions[5], it is evidenced the suggestion of the importance of intensificating health actions directed at controlling overweight among women, focusing on the health guidelines that aim at stimulating the physical activity practice and the adoption of a healthy diet.

With regard to stress, it is observed that this is an increasingly present issue in the lives of contemporary

women, given the multiple roles that they have assumed in society, acting as caretaker and keeper of the home, and as a provider of services outside the home environment[23]. Excessive and continuous stress can generate demotivation, irritability, personal misfortune, among other factors that lead to the development and/or aggravation of countless diseases such as hypertension and atherosclerosis[24,25]. Nevertheless, the importance of stress on the individuals' health conditions, in many cases, is only perceived with the onset of physical symptoms[24], what might explain the fact of not being considered priority for health maintenance in this study, as well as in the first study developed with similar goals[5].

Speculating on the influence of socioeconomic factors in determining attitudes and practices considered important for maintaining health, a study of adult men and women residents in the South and Northeast regions shows that these factors were significantly associated[5]. Such results diverge from the findings of this study, that occurrence being liable to be inserted within the sex differential. Overall, regardless of the socioeconomic characteristics, women evidence greater concern about their health than men, in addition to the existence of a larger number of health programs in the Basic Health Units targeting the female population[26].

Knowledge of the degree of importance attached by the population to health risk factors is important, so that primary care professionals can implement strategies that foster the adoption of healthy lifestyle habits. From this perspective, there is still a strong presence of the biomedical model in healthcare provided in Brazil, which implies a performance that prioritizes the disease, neglecting the psychological, social, and environmental aspects of the health/disease process[23].

In this direction, the need for reorientation of the health practices is verified, with emphasis on health education actions as well as the renewal of commitments and responsibilities between the government, the community, and individuals in the health promotion process[27]. To that end, the effectiveness of educational practices depends on the of the students' critical participation and the integration of the subject with their reality, taking into account their living conditions, beliefs, habits, and knowledge[27,28]. Considering the dialogic model of critical-social pedagogy propagated by Paulo Freire, the user should be recognized as subject bearer of knowledge of the health-disease process, able to establish a dialogical interlocution with the health service and develop a critical analysis of reality[27].

However, it is emphasized that health education alone does not guarantee the improvement of the population's health conditions, due to multiple factors comprised in the health-disease process. It is known that no individual chooses to live with a risk factor of their own accord. A smoker, for example, knows and feels the harmful effects of their addiction. However, quitting smoking goes through much more complex factors than access to information, such as the affective life, the social aspects, the cultural values, the economic status, among other things. Therefore, scientific information is considered only one of the factors that, within a suitable model, can significantly contribute to the change of habits [29].

With regard to women, it is important to emphasize the contributions of the national policy of attention to women's health, which highlights the need to see it in its entirety. This process supports the achievement of resolving actions, built according to the specificity of the female life cycle and the context in which the needs are generated[30,31].

CONCLUSION

The studied population recognizes healthy diet, not smoking, and regular consultations to the doctor as important factors for health maintenance. In turn, the regular practice of physical exercise, no excessive alcohol consumption, maintaining the ideal weight, and stress control were less cited.

A população estudada reconhece a alimentação saudável, o não tabagismo e as consultas médicas regulares como fatores importantes para a manutenção da saúde. Por sua vez, a prática regular de exercício físico, o consumo não excessivo de álcool, a manutenção do peso ideal e o controle do estresse foram menos citados.

REFERENCES

1. Silva DAS, Pereira IMM, Almeida MB, Silva RJS, Oliveira ACC. Estilo de vida de acadêmicos de educação física de uma Universidade Pública do Estado de Sergipe, Brasil. Rev Bras Ciênc Esporte. 2012;34(1):53-67.

2. Pardo-Torres MP, Núñez-Gómez NA. Estilo de vida y salud en La mujer adulta joven. Aquichán. 2008;8(2):266-84.

3. Ministério da Saúde (BR), Secretaria de Políticas de Saúde. Projeto Promoção da Saúde. As Cartas da Promoção da Saúde. Brasília: Ministério da Saúde; 2002. (Série B. Textos Básicos em Saúde).

4. Carvalho ST, Corral-Mulato S, Coscrato G, Bueno SMV. Interface da educação e saúde através da pesquisa-ação. In: III Congresso Internacional de Pedagogia Social; 2010 Mar 1-15; São Paulo. São Paulo: Associação Brasileira de Educadores Sociais; 2010.

5. Siqueira FV, Nahas MV, Facchini LA, Silveira DS, Piccini RX, Tomasi E, et al. Fatores considerados pela população como mais importantes para manutenção da saúde. Rev Saúde Pública. 2009;43(6):961-71.

6. Riquinho DL, Gerhardt TE. A transitoriedade nos estados de saúde e doença: construção do cotidiano individual e coletivo em uma comunidade rural. Trab Educ Saúde. 2010; 8(3):419-37.

7. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Política nacional de atenção integral à saúde da mulher: princípios e diretrizes. Brasília: Ministério da Saúde; 2011. (Série C. Projetos, Programas e Relatórios).

8. Trindade WR, Ferreira MA. Grupo feminino de cuidado: estratégia de pesquisa-cuidado à mulher. Rev Bras Enferm. 2009;62(3):374-80.

9. Silva DMPP, Tomanik EA. Morbidade referida por moradores ribeirinhos de Porto Rico, PR, Brasil. Rev Bras Enferm. 2010;63(3):452-8.

10. Thum MA, Ceolin T, Borges AM, Heck RM. Saberes relacionados ao autocuidado entre mulheres da área rural do Sul do Brasil. Rev Gaúcha Enferm (Online). 2011;32(3):576-82.

11. Carneiro HS. Comida e sociedade: significados sociais na história da alimentação. História Questões Debates. 2005;42:71-80.

12. Instituto Nacional de Câncer, Organização Pan-Americana da Saúde. Pesquisa especial de Tabagismo – PETab: relatório Brasil. Rio de Janeiro: Instituto Nacional de Câncer; 2011.

13. Scarinci IC, Bittencourt L, Person S, Cruz RC, Moysés ST. Prevalência do uso de produtos derivados do tabaco e fatores associados em mulheres no Paraná, Brasil. Cad Saúde Pública. 2012;28(8):1450-8.

14. Malta DC, Moura EC, Silva SA, Oliveira PPV, Silva VLC. Prevalência do tabagismo em adultos residentes nas capitais dos estados e no Distrito Federal, Brasil, 2008. J Bras Pneumol. 2010;36(1):75-83.

15. Fernandes LCL, Bertoldi AD, Barros AJD. Utilização dos serviços de saúde pela população coberta pela Estratégia de Saúde da Família. Rev Saúde Pública. 2009;43(4):595-603.

16. Pitanga FJG, Lessa I. Prevalência e fatores associados ao sedentarismo no lazer em adultos. Cad Saúde Pública. 2005;21(3):870-7.

17. Santos VEP, Cruz NM, Moura LA, Moura JG, Matos KKC. O estado nutricional e comportamento alimentar de um grupo de mulheres na Estratégia de Saúde da Família. Rev Enferm UFSM. 2012;2(2):394-400.

18. Costa PRF, Assis AMO, Silva MCM, Santana MLP, Dias JC, Pinheiro SMC, et al. Mudança nos parâmetros antropométricos: a influência de um programa de intervenção nutricional e exercício físico em mulheres adultas. Cad Saúde Pública. 2009;25(8):1763-73.

19. Mendes MA, Rombaldi AJ, Azevedo MR, Bielemann RM, Hallal PC. Fontes de informação sobre a importância da atividade física: estudo de base populacional. Rev Bras Ativ Fís Saúde. 2010;15(3):163-9.

20. Galduróz JCF, Caetano R. Epidemiologia do uso de álcool no Brasil. Rev Bras Psiquiatr. 2004;26(Supl 1):S3-S6.

21. Mendes MC, Cunha JRF, Nogueira AA. A mulher e o uso de álcool. Rev Bras Ginecol Obstet. 2011;33(11): 323-7.

22. Instituto Brasileiro de Geografia e Estatística. POF 2008-2009: antropometria e estado nutricional de crianças, adolescentes e adultos no Brasil. Brasília: Instituto Brasileiro de Geografia e Estatística; 2010.

23. Ferreira Filha MO, Dias MD, Andrade FB, Lima ÉAR, Ribeiro FF, Silva MSS. A terapia comunitária como estratégia de promoção à saúde mental: o caminho para o empoderamento. Rev Eletrônica Enferm. 2009;11(4):964-70.

24. Sadir MA, Bignotto MM, Lipp MEN. Stress e qualidade de vida: influência de algumas variáveis pessoais. Paideia (Ribeirão Preto). 2010;20(45):73-81.

25. Rodrigues A, Guerra M, Maciel MJ. Impacto do stress e hostilidade na doença coronária. Rev SBPH. 2010; 13(1):107-35.

26. Cotta RMM, Batista KCS, Siqueira KC, Reis RS, Souza GA, Dias D, et al. Perfil sociossanitário e estilo de vida de hipertensos e/ou diabéticos, usuários do Programa de Saúde da Família no município de Teixeiras, MG. Ciênc Saúde Coletiva. 2009;14(4):1251-60.

27. Alves VS. Um modelo de educação em saúde para o Programa Saúde da Família: pela integralidade da atenção e reorientação do modelo assistencial. Interface Comun Saúde Educ. 2005;9(16):39-52.

28. Freire P. Educação como prática da liberdade. 26ª ed. Rio de Janeiro: Paz e Terra; 2002.

29. Veras R. Envelhecimento populacional: desafios e inovações necessárias para o setor de saúde. Med HUPE-UERJ. 2008:7(1):13-20.

30. Freitas GL, Vasconcelos CTM, Moura ERF, Pinheiro AKB. Discutindo a política de atenção à saúde da mulher no contexto da promoção da saúde. Rev Eletrônica Enferm. 2009;11(2):424-8.

31. Coelho EAC, Silva CTO, Oliveira JF, Almeida MS. Integralidade do cuidado à saúde da mulher: limites da prática profissional. Esc Anna Nery Rev Enferm. 2009;13(1):154-60.

Mailing address:
Márcia Cristina Sales
Universidade Federal do Rio Grande do Norte
Rua General Gustavo Cordeiro de Farias, s/n
Bairro: Petrópolis
CEP: 59010-180 - Natal - RN - Brasil
E-mail: cristina.salles@yahoo.com.br