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Araştırma / Research Article

18-64 yaş arasındaki kadınlarda sağlıklı yaşam biçimi davranışları ve koruyucu sağlık uygulamaları: Çorum ili örneği

Healthy lifestyle behaviors and preventive health applied to women ages 18-64: a sample from the Çorum province

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ÖZET

Amaç: Bu çalışmanın amacı 18-64 yaş arasındaki kadınlarda sağlıklı yaşam biçimi davranışlarını ve koruyucu sağlık uygulamalarını belirlemekti. **Yöntem:** Tanımlayıcı ve kesitsel türdeki bu araştırma Aralık 2014 tarihinde iki aile sağlığı merkezine başvuran 249 kadın ile gerçekleştirildi. Kadınların sağlıklı yaşam biçimi davranışlarını belirlemek amacıyla Sağlıklı Yaşam Biçimi Davranışları Ölçeği (48 madde) kullanıldı. **Bulgular:** Ölçeğin tamamından alınan puanların ortalaması 115,78±36,20 olup madde puan ortalaması 2,57±0,46 olarak bulundu. En yüksek puanlar kişilerarası destek ve en düşük puanlar egzersiz alt boyutuna aitti. Kadınların yaş grubu, çalışma durumu, sigara içme ve fiziksel aktivite yapma durumu, beden kitle indeksi ve genel sağlık algısı ölçekten alınan puanlar üzerinde etkili olan değişkenlerdi. Bir önceki yıl içinde kan glikoz ve kolesterol düzeylerini ölçtürmeyen, kendi kendine meme muayenesi yapmayan ve mamografi çektirmeyen kadınlar, diğer kadınlara göre anlamlı ölçüde daha düşük sağlık sorumluluğu, kendini gerçekleştirme, egzersiz ve stres yönetimi puanlarına sahipti. **Sonuç:** Bu çalışmada kadınların sağlıklı yaşam biçimi davranışları "orta düzeyde" bulundu. Ölçekten alınan puanların riskli sağlık davranışlarına sahip ve koruyucu sağlık uygulamalarını yerine getirmeyen kadınlarda daha düşük olduğu belirlendi. Koruyucu sağlık hizmetlerinde 18-64 yaş arasındaki kadınlara sağlık eğitimi ve danışmanlık hizmetleri verilmeli, kadınlar sağlığı geliştirme uygulamalarına katılmaları yönünde teşvik edilmelidir.

ABSTRACT

Aim/background: The aim of this study was to determine healthy lifestyle behaviors and preventive health applied among women ages 18-64 women. **Methods:** This descriptive and cross-sectional study was performed in December 2014 in the two family health centers with 249 women. To determine healthy lifestyle behaviors of women, the Healthy Lifestyle Behaviors Scale-48 items were used. **Results:** The total average score from the scale was 115.78±36.20 and the average scores from the items were 2.57±0.46. The highest average scores were obtained from interpersonal support sub dimension, the lowest were from exercise. Age groups, working status, smoking, physical activity, body mass index and general health perceptions were the effective variables on scores. Women who didn't measured their blood-glucose and cholesterol level, who didn't practice self-breast examination and mammography during the last year, had significantly lower health responsibility, self-actualization, exercise, and stress management scores. **Conclusion:** In the present study we found healthy lifestyle behaviors of women in "moderate levels". Scores obtained from scale were low in women who had risky health behaviors and didn't implement preventive health applications. In preventive health care, health education, and counselling services should be given to women aged 18-64, women should be encouraged to participate in health promoting programmes.

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INTRODUCTION

The World Health Organization (WHO) reported that 57 million deaths occurred in 2008, of those deaths 63.0% stemed from the non-communicable diseases. Also it is stated that a large number of these diseases can be avoided by reducing four basic behavioral risk factors such as tobacco and alcohol use, physical inaktivity and unhealthy eating (1). Health- the most important dimension of life quality- is affected by socio-economic, cultural, environmental, behavioral and biological factors. "Healthy lifestyle practices" which reduce and eliminate behavioral risk factors are an important position among the determinants of health (2). In order to be healthy, people need to adopt healthy lifestyles and basic lifestyle behaviors, and need to implement them by converting these behaviors to attitudes for preventive health applied (3,4). Women's health not only leaves a significant impact on women but also it affects the health of future generations, for this reason it is an essential and effective step for strengthening the preventive health care system (5).

By 2012, the Turkish population was approximately 76 million and 49.8% were women (6). According to data from the 2013 Health Statistics, 65.1% of the women never practiced BSE, 80.4% didn't have any mamography, and 77.9% didn't have any pap-smear attempted. Also,

only more than one-third of the women measured their blood glucose and cholesterol levels in the last 12 months (6). It is necessary to impose health-promoting behaviors and acquire preventive health applied to individuals for controlling avoidable risk factors of chronic diseases in era (7). It will contribute to the development of health in women, which are nearly half of our population, women's health promotion programs should be moved to the forefront of preventive health services.

This study was aimed to shed light on risk reduction in women's lifestyle by determining health lifestyle behaviors and affecting factors in women ages 18-64 who applied to the family health centers.

METHODS

This descriptive and cross-sectional study was conducted in December 2014 in Çorum. The population of this study consisted of 310 women ages between 18-64 who applied to the family health centers during the study. Without sample selection we performed the question forms to 249 women by face- to face interview. The achievement rate was 80.3%. The other women were unwilling to participate in the study. To collect data, we used a 20-item questionnaire which asking socio-demographic features, lifestyles related with health, perceived health and preventive health applied such as measuring blood-glucose and cholesterol levels, applied breast self examination (BSE), mammography and pap-smear tests within the last one year. Also we used the Healthy Lifestyle Behaviors Scale (HPLP-48 tem) which was developed by Walker and et al in 1987 (8), and structured Turkish validity and reliability by Esin in 1997 (9). The scale has six sub-dimensions in the form of self-actualization, health responsibility, exercise, nutrition, interpersonal support, stress management. Self-actualization sub-dimension (13 items), determines one's purpose of life, their individual ability to actualize themselves, and how much they know about themselves and how much they could satisfy themselves. A health responsibility sub-dimension (10 items) determines the level of responsibility one has for their health and how much they take care of their health. Exercise sub-dimension (5 items) determines how much one carries out exercises which are indispensable for a healthy life. Nutrition sub-dimension (6 items) determines one's values in selecting and arranging their meals and food selection. Interpersonal support sub-dimension (7 items) determines the level of one's communication with those with whom they have intimate relations and the continuity of this communication. Stress management (7 items) determines the level of one's familiarization with sources of stress and stress control mechanisms (9). All items of the scale are positive and were prepared in 4-point Likert type. Each item is scored with the numbers 1=never, 2= sometimes, 3=often and 4=regularly. The minimum score is 48 and the maximum score is 192. Scores 48-96 show "low levels", between 97-144 "mid levels", between 145-192 "high levels". The increase in the scores obtained from the scale shows that the person performed healthly behaviors at a high level. Crobach alpha coefficient was found 0.91 by Esin (9). We also found crobach alpha as coefficient 0.91. The data was analysed by using the SPSS 17.0 packet program with an Independent test and One-Way Anova (Post-Hoc Tukey).

The study was planned in accordance with the Helsinki principle and ethical approvals were taken from the Bozok University Faculty of Medicine (Research Protocol No:30.09.2013/173).

RESULTS

The average age of for the women was 29.60 ± 12.69, 57.4% of which were between the ages of 18-28, 44.6% of the women were married, 75.5% had a high school and over education level, 8.4% were employed, 64.3% were living in the city center.

The distribution of the scores obtained from the HPLP is shown in Table 1. The average total score from the HPLP was 115.78±36.20 and the average scores from the items were 2.57±0.46. The highest average scores were obtained from interpersonal support subdimension, the lowest were from exercise.

Table 1. Distribution of HPLP scores for women

Scale	Min-max scores	Obtained Min-max scores	Means of score $\bar{X}$ ± SS	Item means of score $\bar{X}$ ± SS
Self actualization	13-52	0-52	35.33±8.98	2.73±0.72
Health responsility	10-40	0-40	22.35±6.83	2.23±0.82
Exercise	5-20	0-20	9.41±3.49	1.88±0.69
Nutrition	6-24	0-24	16.49±4.40	2.76±0.71
Interpersonal support	7-28	0-28	19.99±4.42	2.89±0.55
Stress management	7-28	0-28	16.97±4.41	2.46±0.55
Total	48-192	0-192	115.78±36.20	2.57±0.46

Table 2. HPLP scores for women according to their age groups and working status

Features	Self Actualization $\bar{X} \pm SS$	Health Responsibility $\bar{X} \pm SS$	Exercise $\bar{X} \pm SS$	Nutrition $\bar{X} \pm SS$	Stress management $\bar{X} \pm SS$	Interpersonal support $\bar{X} \pm SS$	Total $\bar{X} \pm SS$
Age groups							
18-24 years (n=143)	34.56±8.46	20.85±5.87	8.92±3.16	15.06±3.72	16.51±4.07	19.39±4.57	110.41±34.88
29-39 years (n=48)	33.92±9.20	22.46±6.55	9.35±3.45	18.04±4.04	16.04±5.13	20.16± 4.31	119.06±30.05
40 and over (n=58)	38.41±9.46	25.98±7.99	10.67±4.02	18.72±4.89	18.87±4.06	21.33±3.84	126.31±41.60
	F:4.677; **p:0.010**	F:12.752; **p:0.000**	F:5.409; **p:0.005**	F:20.909; **p:0.000**	F:7.674 **p:0.001**	F:4.113; **p:0.018**	F:4.341;**p:0.014**
Working status							
Working (n=21)	34.62±10.38	22.95±9.10	9.43±3.41	17.86±4.10	17.48±4.65	20.52±3.76	118.38±39.15
Non-working (n=228)	35.39±8.86	22.30±6.60	9.41±3.51	16.36±4.41	16.93±4.39	19.94±4.48	115.54±35.99
	t:0.380; p:0.470	t:-0.417; **p:0.035**	t:-0.026; p:0.806	t:-1.493; p:0.691	t:-0.547;p:0.612	t:-0.576; p:0.477	t:-0.344; p:0.541

The distribution of the HPLP scores according to women's ages and occupational status are given in Table 2. For the age groups difference between all of the scale scores was statistically significant ($p<0.05$). The average scores from the total scale was 110.41±34.88 in women aged 18-24 age group and was 119.06 ± 30.05 in women aged 29-39. Women who were aged in their 40 and over had higher scores with 126.31±41.60. Women who stated that they are working any occupation had higher scores than non-working, for health responsibility the sub-dimension difference was statistically significant ($p<0.05$).

Various health behaviors and preventive cancer applied to women are shown in Table 3.

A total of 24.7% of the women had at least one chronic disease, without disease 73.1% of the women reported that they went to the doctor, 45.0% of the women who said they measured their blood glucose, 43.8% of the women measured their hemoglobin level. In contrast, 27.4% of the women were doing breast selfexamination (BSE) and 18.5% of the women had mammography, that 15.7% had a pap-smear test and 10.4% of of the women were measured for their bone density. Results showed that 53.0% of the women qualified their general health as "good" and 9.7% of the women were doing regular physical exercise. The prevalence of smoking among women was 9.6% and the prevalence of obesity was 28.5%.

According to various health behaviors of women the distribution of the HPLP scores are shown in Table 4.

The average total scores were 116.45±33.68 in non-smokers and were 118.13±43.93 in quite smoking. Total scores were lower in current smokers with 107.83±47.54. For smoking status there was a difference between the scores obtained from the nutrition sub-dimension that scores were found lower in current smokers ($p<0.05$). According to doing physical activity differences between the other sub-dimensions were siginificant except nutrition-dimension ($p<0.05$). The average total scores were 138.00±18.65 stated that doing regular physical activity. Total scores were lower in sedentary and irregular active women ($p<0.05$). Women, whose body weight was at optimal level, had higher total scores as 125.31±34.75 than underweight and obese women. Also scores were siginificantly higher in health responsibility, exercise, nutrition and interpersonal support sub-dimensions in women with normal body weight ($p<0.05$). Women who qualified their general health as good, had higher scores with 117.98±34.65 but it wasn't significantly higher than the mid and bad groups. However, scores from nutrition sub-dimension were significantly higher in good health perceiving ($p<0.05$).

Table 3. Health behaviors and preventive health applied to women

Chronic disease		Number	%
Had		61	24.7
Had not		188	75.3
Visit to doctors without any disease in last one year			
Yes		182	73.1
No		67	26.9
Applied to BSE in last one year			
Yes		68	27.4
No		181	72.6
Applied to mammography in last one year			
Yes		46	18.5
No		203	81.5
Applied to pap-smear test in last one year			
Yes		39	15.7
No		210	84.3
Physical activity			
Doing none		75	30.1
Doing sometimes		150	60.2
Doing regularly		24	9.7
Smoking status			
None		201	80.8
Quit smoking		24	9.6
Current smoker		24	9.6
BMI			
<18.5	Underweight	34	13.7
18.5-24.9	Normal	144	57.8
> 25.0 ve üzeri	Obese	71	28.5
Total		**249**	**100.0**

Table 4. HPLP scores for women according to health behaviors

	Self actualization $\bar{X} \pm SS$	Health responsibility $\bar{X} \pm SS$	Exercise $\bar{X} \pm SS$	Nutrition $\bar{X} \pm SS$	Stress management $\bar{X} \pm SS$	Interpersonal support $\bar{X} \pm SS$	Total $\bar{X} \pm SS$
Smoking status							
None (n=201)	35.38±8.52	22.07± 6.75	9.26±3.28	16.51±3.98	17.06±4.34	19.84±4.48	116.45±33.68
Quit smoking (n=24)	34.54±12.94	23.79±8.27	10.33±4.02	18.25±4.04	16.79±5.58	21.08±4.25	118.13±43.93
Current smoker (n=24)	35.75±8.32	23.29±5.40	9.75±4.51	14.58±6.86	16.42±3.75	20.16±3.36	107.83±47.54
	F:0.121; p:0.886	F:0.926; p:0.398	F:1.142; p:0.321	F:4.294; **p:0.015**	F:0.249; p:0.780	F:0.869; p:0.421	F:0.661; p:0.517
Physical activity							
None (n=75)	34.73±7.64	21.45±7.05	7.44±2.71	15.89±4.04	16.04±4.05	19.53±4.34	111.52±32.23
Sometimes (n=150)	34.87±9.74	22.26± 6.44	9.63±3.06	16.53±4.57	16.97±4.54	19.89±4.60	114.35±39.00
Regular (n=24)	40.06±6.33	25.79±6.46	14.21±3.16	18.08±4.08	16.42±3.75	22.04±2.29	138.00±18.65
	F:3.807; **p:0.024**	F:3.791 **p:0.024**	F:48.096;**p:0.000**	F:2.299; p:0.103	F:7.227; **p:0.001**	F:3.078; **p:0.048**	F:5.337; **p:0.005**
BMI							
Underweight (n=34)	35.21±7.69	21.41±5.79	9.68±3.45	14.88±2.88	16.76±4.32	19.53±5.98	109.71±37.47
Normal (n=144)	36.14±10.92	24.18±7.69	10.25±3.81	18.21±4.17	17.66±5.11	21.11±4.43	125.31±34.75
Obese (n=71)	34.96±8.23	21.68±6.47	8.93±3.30	16.02±4.55	16.63±4.03	19.55±3.88	112.51±35.95
	F:0.410; p:0.664	F:3.647; **p:0.027**	F:3.599; **p:0.029**	F:9.094; **p:0.000**	F:1.224; p:0.296	F:3.257; **p:0.040**	F:3.599; **p:0.029**
General health perception							
Good (n=132)	36.16±8.64	21.69±7.04	9.62±3.63	17.14±3.62	17.10±4.60	20.24±4.44	117.98±34.65
Mid (n=103)	34.69±9.01	23.17±6.50	9.26±3.30	15.68±5.21	16.99±4.17	19.70±4.56	113.71±37.94
Bad (n=14)	32.21±11.27	22.71±6.96	8.50±3.65	16.34±3.69	15.64±3.34	19.71±2.87	110.21±38.62
	F:1.669; p:0.191	F:1.375; p:0.255	F:0.807; p:0.447	F:3.241; **p:0.041**	F:0.690; p:0.503	F:0.450; p:0.638	F:0.577; p:0.562

Distribution of the HPLP scores for various preventive health applied to women in the last year are shown in Table 5

Women who reported that they measured their blood-glucose levels in the last year had siginificantly higher scores from health responsibility sub-dimension. For measuring cholesterol levels women's HPLP scores were higher than non-measured women for self-actualization, health responsibility, exercise and stress management ($p<0.05$). Women who applied BSE and mammography in the last year had higher scores, scores were significantly higher for self-actualization, health responsibility, exercise ($p<0.05$). There was no significance to the applied pap-smear test.

DISCUSSION

Preventive health application is an important step in a healthy life style for reduction risks and individual's health responsibilities. In the present study we found healthy life style behaviors of women in moderate levels (Table 1). In our country, just as in studies upon students (7,10) and educators (11,12) also studies in various age groups of women have showen that the HPLP scores were at a moderate level (13-15). Also the same results were reported in studies Jordanian (16), Taiwanese (17) and Afro American (18) women.

In addition, the studies showed women's ages weren't effective on healthy lifestyles (19,20), some studies exist that women with an advance age performed healthy lifestyles (14). In our study women aged 40 and over had significantly higher scores from the total scale of the HPLP (Table 2). When we thought chronic diseases were generally seen in middle aged women, these higher scores in ages 40 and over can be an indicator for disease management and maintaining health. We found working women were performing a health lifestyle behaviors especially health responsibility (Table 2). Studies on the same track in our country showed that working women had higher healthy lifestyle behaviors (13,14,20). Female labour can contribute to the rising education levels, using health care services overly and progressing health senses.

In the present study, three in four women went to the doctor without a disease and yet it was determined under half of the women measured their blood-glucose and cholesterol levels, one in ten women measured their bone density in the last year. The amount of women performing screening tests was very low (Table 3). Similar results obtained from with in our country showed that Turkish women were using preventive health services poorly (6,21,22). Recommendations according to the Guide to Clinical Preventive Services 2014 about optimal screening interval were every 3 years for blood glucose and every 5 years for cholesterol level (23). Although screening methods are a vital role in reducing deaths related to cancers in women, screening rates in BSE, mammography and pap-smears are low in many Muslim countries, including Turkey, due to the traditional and religious beliefs (21,24,25). In 2012, one in three women aged 15 and over had implemented a BSE in the last year nationwide. Results from the same study

Table 5. HPLP scores for women according to various preventive applied in the last year

	Self actualization $\bar{X} \pm SS$	Health responsibility $\bar{X} \pm SS$	Exercise $\bar{X} \pm SS$	Nutrition $\bar{X} \pm SS$	Stress management $\bar{X} \pm SS$	Interpersonal support $\bar{X} \pm SS$	Total $\bar{X} \pm SS$
Blood-glucose							
Measured (n=112)	35.69±10.18	24.29±7.57	9.81±3.74	17.39±4.32	17.54±5.99	20.24±4.87	120.29±37.47
Non measured (n=137)	35.04±7.89	20.77±5.71	9.08±3.25	15.75±4.33	16.51±4.21	19.78±4.01	112.09±34.83
	t:0.562; p:0.110	t:4.180; p:0.017	t:1.651; p:0.128	t:2.977; p:0.622	t:1.834; p:0.328	t:0.804; p:0.454	t:1.784; p:0.540
Cholesterol							
Measured (n=84)	36.35±10.81	24.96±8.00	10.01±4.09	17.89±4.21	17.61±5.04	20.56±4.76	122.01±40.23
Non measured (n=165)	35.03±7.41	21.08±5.71	9.12±3.11	15.82±4.30	16.70±3.99	19.75±4.19	113.00±33.37
	t: 1.126; p:0.004	t:4.403; p:0.048	t:1.909; p:0.004	t:3.614; p:0.986	t:1.554; p:0.016	t:1.375; p:0.666	t:1.874; p:0.160
BSE							
Applied (n=68)	36.00±10.56	24.85±8.28	10.13±4.11	19.12±3.23	17.91±4.77	21.32±3.77	123.85±38.17
Non applied (n=181)	35.08±8.35	21.45±5.96	9.14±3.21	15.52±4.38	16.62±4.24	19.46±4.55	112.75±35.16
	t:0.711; p:0.113	t:3.583; p:0.180	t:1.995; p:0.005	t:6.167; p:0.054	t:2.074; p:0.229	t:3.001; p:0.742	t: 2.166; p:0.630
Mammography							
Applied (n=46)	35.78±12.41	25.39±9.44	11.09±4.40	19.20±3.88	18.30±5.21	21.26±4.19	124.41±42.86
Non applied (n=203)	35.23±8.04	21.67±5.90	9.03±3.14	15.88±4.28	16.67±4.16	19.70±4.42	124.41±42.86
	t: 0.375; p:0.003	t:3.408; p:0.001	t:3.698; p:0.001	t:4.827; p:0.466	t:2.290; p:0.067	t:2.175; p:0.564	t:1.800; p:0.118

showed implementing mammography and pap-smears didn't draw the line 10.0% in the last year (21). However we found that women who applied preventive health in the last year had higher healthy lifestyle behaviors (Table 5). Health screening leads to the early diagnosis of chronic illness, giving roles to people understanding the value of their own health, taking responsibility, managing effectively the disease process. People assumed this role is expected to fulfill the necessary components in a healthy lifestyle. Our results were in line with other studies (26, 27).

Obesity is increasing in an alarming rate parallel to lifestyle changes in both developed and developing countries (28). In this study when examining the behavioral risks in women, it was determined that one-third of the women were obese (Table 3). Obesity rates from this study were higher than our country-wide studies, but were close to the results of the regional studies. Indeed, according to the results conducted by the Turkey Statistics Institution in our country, nearly one in five women over and the age of 15 were obese (29). Studies have shown the body type was not effective on women's healthy lifestyle behaviors (20,22). Differently in this study, it was found that women who maintainig their body weight in optimal levels had significantly higher healthy lifestyle behaviors (Table 4).

In most countries due to increased physical inactivity, it is reported the general health was negatively affected in individuals (30). Physical inactivity is a risk factor contributing to death, by 8.0% are attributed to chronic diseases in women aged 20 and over in the world (5). At the national level, studies showed that physical inactivity were extensive among Turkish women. According to results from the Turkey Nutrition and Health Survey, two of every five women in our country were inactivite physically (31). In the present study one-third of the women did not do any physical activity but women doing regular physical activity were performing higher healthy lifestyle behaviors (Table 3-4). This situation can be caused from social impacts as well as may be due to lack of knowledge about the benefits of physical activity throughout life in women.

Tobacco use is one of the most serious avoidable risk factors for premature death and disease in adult women. Without continued action to reduce smoking, deaths among women aged 20 years and over will rise from 1.5 million in 2004 to 2.5 million by 2030 (5). According to the Turkey Statistic Institution, the results of smoking prevalance in women aged and over 15 were 13.1% in our country (29). In this study, the prevalence of smoking in women was found to be lower than 10.0%. Women who quit smoking received higher scores and significances were seen in nutrition sub-dimension obviously. These results gave us the impression that women had a bad influence in their eating habits due to smoking, so they went the risk reduction way in their lifestyles (Table 3-4).

A Positive health perception is considered a motivational source to sustain and improvehealth, also studies reported that women who described their general health as good had healthly lifestyle behaviors (17,22). Similar results were found in our study (Table 4).

CONCLUSION/RECOMMENDATION

In the present study we found healthy lifestyle behaviors for women in a "moderate level". Scores obtained from the scale were low in women having risky health behaviors and didn't implement preventive health

applications. The HPLP can be used on Turkish women. However, in preventive health care, health education, and counselling services should be given to women aged 18-64, women should be encouraged to participate in health promoting programmes.

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CONFLICTS OF INTEREST

None

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