

Who Empowers Women Towards Healthier Lifestyles? Example from Western Croatia

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ABSTRACT

This article explores who among the doctors, other health care workers, family or somebody else most frequently advised women about their lifestyle changes related to cardiovascular health (including smoking, nutritional habits and physical activity). We analyzed who advised the most, in relation to the parameters important in the etiology of cardiovascular diseases: age, systolic blood pressure and body mass index (BMI). Sample was a part of comprehensive Croatian Adult Health Survey, comprised of women from Primorje-Goran, Istra and Lika-Senj Counties. Results indicated low frequency of advising on lifestyle changes in primary health care in all three counties, with most advice from general practitioners on nutritional habits. Family and other health care workers advised about smoking and nutrition and had strong influence in the youngest age groups. The GPs failure to counsel younger population and disease-free women could be regarded as the missed opportunity for avoidance of preventable risk factors that are associated with cardiovascular diseases. Other subjects in the health care process, as well as the family and media could fill the gaps between the patients and health care system messages. In order to create and develop such heterogeneous network approaches to training various programs and activities have to take into account all specific gender and regional characteristics.

Key words: healthy lifestyle, women, cardiovascular diseases, Croatian Adult Health Survey, Croatia

Introduction

Successful health policies have to approach person and/or population in a holistic manner, taking into account both biological and cultural contexts¹⁻⁴. The fact that individual behavioral patterns have a key role in the development and progress of many health problems has led to the development of health education as a professional and scientific field. Towards the end of 80's a new term appeared – the health promotion, which was defined in the Ottawa declaration⁵ as a process that enables individuals or populations to increase control over their health and improve it. In essence, it has been articulated, probably for the first time that health education can reach its full potential only if it is structurally supported by the community through its politics and laws. Our lifestyle influences our health⁴, and our lifestyle is influenced by numerous factors that are predominantly outside the health sector (including the cultural differences, education, work status, income, social status, living environment, network of social support, capability of con-

fronting, social justice, equality, stress, gender, violence, war etc). Nevertheless, when we employ a holistic approach to health we can see that all those elements are in the domain of health care^{2,4}. Modern concept of a health care system should be based on prevention, which is strongly supported by health education and health promotion, rather than curative medicine only.

Obesity, smoking and physical inactivity are well recognized risk factors in the etiology of cardiovascular diseases (CVD)⁶⁻⁸. Therefore, one of the main areas of health education is the promotion of changes of the risky lifestyle and raising the awareness on their important role in the CVD morbidity^{1,2}. One of the core competences of general practitioner (GP) is the knowledge on the principles of lifestyle improvements and ability to give advice to high risk patients. Many studies have demonstrated that health promotion is taking part during routine practice⁹⁻¹¹, but this counseling is often affected

by lack of time, GP's and patient agreement on risk factors, GP's beliefs about effectiveness of counseling, and GP's communication skills^{12–14}. Beside GP's in primary care settings, healthier lifestyle could be promoted through numerous health campaigns^{15,16}, supported by various media, but also through the family and friends networks.

Literature offers evidence that certain patients' characteristics (gender particularly) could have a strong predictive power in the extent and the quality of health care that patients receive, and whether they receive and adopt advice from physicians regarding lifestyle changes^{17,18}. Women as a target group for lifestyle changes have dual positive role: behavior changes and knowledge about healthy lifestyle could improve their own health status, as well as the entire family, as women are creators of their family's lifestyle. Knowledge and competences acquired in family and in early ages in most cases remain as dominant routine throughout the whole life^{19,20}.

Physical inactivity, overweight and inadequate nutrition alongside smoking are the leading causes of cardiovascular diseases development in women^{6,7,8,21}, together with diabetes type 2^{6,7}. Leading cause of morbidity in Primorje-Goran, Istra and Lika-Senj Counties are respiratory diseases, while on the second and third place are cardiovascular diseases. On the other hand leading cause of mortality are cardiovascular diseases in all three counties with occurrence between 51 and 63% in all causes mortality^{22–24}. For the comparison, on the second place are malignant diseases with the proximally half of the occurrence of the cardiovascular diseases (between 17 and 23%). Out of 10 leading causes of death, a total of 5 were from the group of cardiovascular diseases (myocardio-pathies, stroke, other ischemic heart diseases, etc)^{22–24}.

It has been shown that regional differences have an important role in identifying small differences that might be important for developing most useful and specific health promotion programs^{25,26}. Population specific approach that takes into account regional cultural and geographic characteristics can reach the most of the users of health care services.

The aim of this study was to explore who out of four categories (doctors, other health care workers, family or somebody else) was the most frequently giving advices about lifestyle changes that might influence morbidity and mortality of cardiovascular diseases in the region comprised of Primorje-Goran, Istra and Lika-Senj Counties. This is of special interest in the areas with lower population density, smaller number of GPs and other constraining factors such as low income or cultural determinants.

Materials and Methods

The data from the Croatian Adult Health Survey from 2003 were used in this study. Additionally, we included only women respondents who were residents of three Croatian counties – Primorje-Goran, Lika-Senj and Istra County. In total there were 885 respondents, most of them from Primorje-Goran County (538; 60.8%), Is-

tarska County (269; 30.4%), while the least respondents were residents of the Lika-Senj County (78; 8.8%). Age span was 18 to 91 years, with an average age of 54.7 years.

We chose three lifestyle parameters – smoking, nutritional habits and physical activity, and investigated who advised the most out of four categories of possible advisors: physicians, other health care workers (i.e. pharmacists, nurses, and dentists), family or somebody else. Also, we analyzed who advised the most in relation to the respondent's characteristics important in the development of cardiovascular diseases: age (classified in three groups of 18–29, 30–64, 65 and more years), systolic blood pressure (above 140 mm Hg) and body mass index (higher than 24.9).

All relevant data were taken from the 2003 Croatia Adult Health Survey (CAHS) designed on multistage stratified sample providing representative sample of general population above the age of 18, living in the private households in Republic of Croatia. Territory of Croatia is administratively divided in 21 counties, that were in CAHS organized in six regions (i.e. Northern, Eastern, Southern, Western, central and City of Zagreb). The questionnaire along with anthropometrics and blood pressure measuring was administrated by trained personnel. Overall response was 84.3%^{27,28}.

Statistical analysis included descriptive statistics and χ^2 test. *P* value <0.05 was considered statistically significant. Software SAS V8.02 (SAS Institute Inc., Cary, NC, USA) licensed to SRCE, site 0082452004, was used in the analysis.

Results

Out of 885 women in this study, a total of 234 stated that they were smokers, and only smaller number got the advice about smoking cessation. Family members advised most commonly (64.5%), while other health care workers advised the least frequently (25.2%). GPs also advised smaller percentage of women (30.8%), along with others (31.6%). Physicians and other health care workers equally advised women in all three age groups, while family members more commonly advised women in middle age group ($\chi^2=13.69$, *p*=0.001).

All women answered the question about the advice regarding nutritional habits, but only a smaller number got the advice; between 8 and 19% depending on who gave advice. GPs gave most of the advice (19.8%), followed by family members (16.6%), while others had the least effect (8.8%). GPs and others gave advice equally to all three age groups, although percentage wise GPs gave most advice to the oldest age group (23%). Significant difference in giving advice by health care workers who gave most advice to the women 65 and above ($\chi^2=16.97$, *p*<0.001), and family, but they give statistically significant most advice to the youngest group (18–29) ($\chi^2=11.99$, *p*=0.002) then other two age groups.

Regarding physical activity, all women answered the question and same as with other lifestyle habits only small number got the advice. Most advice came from the family (13.1%), while others once again had the least effect (6.4%). GPs gave advice to 12.1% and other health care workers only to 7.7% of women. For the physical activity GPs, other health care workers and family equally give advice to all three age groups. The only statistically significant difference is in the group of others ($\chi^2=11.89$, $p=0.003$), who give most of the advice to the youngest age group, less to the group of 65 and above and the least to the group of women between 30 and 64 years. Percentage wise, again, family members gave most advice to the youngest age group (17.1%), while GPs to the group of 65 and above (14,0%).

Table 1 and Table 2 shows the women with higher than normal BMI (above normal category I, above normal category II and obese) in relation who advised them about nutritional habits and physical activity. Women with increased BMI got little advice to stop smoking from all categories except family who percentage wise gave more advice. There is no significant difference among physicians, other health care workers, family and others in giving advice to stop smoking in relation to BMI categories. It is interesting that thin women get most advice from family to stop smoking.

As for BMI and nutritional habits again small number of women got the advice. There was significant difference in frequency of giving advice by GPs and other health care workers; they both gave more advice to the women with increased BMI.

Regarding physical activity in general small number of women with BMI above normal is advised from 6.3% to 15%, these are the lowest percentage values among all three examined lifestyles. GPs and other health care workers give advice that is statistically significantly higher for women with above normal BMI.

In Table 3 and Table 4 are presented relations between women with higher than normal systolic blood pressure and who advised them about smoking cessation and nutritional habits. For higher than normal, systolic blood pressure, small number of women is advised to stop smoking. Percentage wise family gives most advice (61.8%). For systolic blood pressure doctors significantly give more advice to the women with normal blood pressure.

To change nutritional habits regarding higher than normal systolic blood pressure GPs and other health care workers statistically significant give more advice than family or someone else. Percentage wise about nutritional habits as risk women are most advised from 15.6% (family) to 27.3% (GPs).

TABLE 1
BODY MASS INDEX IN RELATION ON WHO ADVISED WOMEN ABOUT CHANGING THEIR NUTRITIONAL HABITS

Advisor	Under normal		Normal		Above normal		χ^2 ; p
	No	Yes	No	Yes	No	Yes	
GP	56 81.2%	13 18.8%	286 88.3%	38 11.7%	367 74.7%	124 25.3%	$\chi^2=22.54$; $p<0.001$
Other health care workers	63 91.3%	6 8.7%	299 92.3%	25 7.7%	410 83.7%	80 16.3%	$\chi^2=14.18$; $p=0.001$
Family	55 79.7%	14 20.3%	281 86.7%	43 13.3%	402 81.9%	89 18.1%	$\chi^2=4.11$; $p=0.128$
Someone else	63 91.3%	6 8.7%	294 90.7%	30 9.3%	449 91.4%	42 8.6%	$\chi^2=0.12$; $p=0.941$

TABLE 2
BODY MASS INDEX IN RELATION WHO ADVISED WOMEN ABOUT INCREASING PHYSICAL ACTIVITY

Advisor	Under normal		Normal		Above normale		χ^2 ; p
	No	Yes	No	No	Ys	No	
GP	66 95.7%	3 4.3%	294 90.7%	30 9.3%	417 84.9%	74 15.1%	$\chi^2=10.43$; $p=0.005$
Other health care workers	68 98.6%	1 1.4%	306 94.4%	18 5.6%	444 90.4%	47 9.6%	$\chi^2=8.48$; $p=0.014$
Family	63 91.3%	6 8.7%	286 88.3%	38 11.7%	419 85.3%	72 14.7%	$\chi^2=2.76$; $p=0.251$
Someone else	65 94.2%	4 5.8%	302 93.2%	22 6.8%	460 93.7%	31 6.3%	$\chi^2=0.13$; $p=0.939$

TABLE 3
SYSTOLIC BLOOD PRESSURE IN RELATION WHO ADVISED WOMEN ABOUT SMOKING CESSATION

Advisor	Normal BP		Higher than normal BP		χ^2 ; p
	No	Yes	No	Yes	
GP	509 83.6%	100 16.4%	200 72.7%	75 27.3%	$\chi^2=13.38$; p<0.001
Other health care workers	549 90.3%	59 9.7%	223 81.1%	52 18.9%	$\chi^2=13.77$; p<0.001
family	505 82.9%	104 17.1%	232 84.4%	43 15.6%	$\chi^2=0.19$; p=0.664
Someone else	551 90.5%	58 9.5%	255 92.7%	20 7.3%	$\chi^2=0.93$; p=0.335

TABLE 4
SYSTOLIC BLOOD PRESSURE IN RELATION WHO ADVISED WOMEN ABOUT NUTRITIONAL HABITS

Advisor	Normal BP		Higher than normal BP		χ^2 ; p
	No	Yes	No	Yes	
GP	133 66.5%	67 33.5%	29 85.3%	5 14.7%	$\chi^2=3.97$; p=0.046
Other health care workers	145 72.5%	55 27.5%	30 88.2%	4 11.8%	$\chi^2=3.03$; p=0.082
family	70 35.0%	130 65.0%	13 38.2%	21 61.8%	$\chi^2=0.03$; p=0.864
Someone else	139 69.5%	61 30.5%	21 61.8%	13 38.2%	$\chi^2=0.49$; p=0.486

Women with both normal and higher systolic blood pressure get the advice about physical activity equally with no significant difference among advisors. Percentage wise doctors and Family advise the most 14.9% and 11.3% respectively.

Discussion

These results indicate low frequency of advising about life style changes in primary health care settings in all three counties. To some extent we can say that implementation of preventive measures for women are not fully integrated in routine general practice visit. It is unclear what the reasons are, but they can be found both on the side of the health care system as well as on the patient's side.

We can speculate based on the results of other authors^{29,30} that women are generally less frequently employed, and due to some objective obstacles such as distance to the nearest medical facility delay in getting an appointment, waiting time and cost of seeing doctor i.e. co-payment and travel cost end up using and getting less preventive health care services. Two out of the three counties are extremely unevenly inhabited with areas of high population density (coastal, big towns) and scarcely inhabited islands and inland, with considerable distances

between villages and nearest town with medical facility. Inland regions are also quite mountainous and the climate attracts small number of physicians to work in these conditions, so some of the communities lack optimal number of GPs³¹. On the other hand sometimes women do not have the same treatment as men. Habitually, specificity of women's health is viewed only through biological aspects meaning gynecological problems and problems in connection with pregnancy which neglected other problems such as chronic and malignant diseases and factors influencing their etiology³². We can try to explain these results with the possibility that is wrongly perceived that women particularly in rural settings of these three counties live more healthy lives (less smoking, alcohol or unhealthy nutritional habits), along with the notion that work in agriculture is equivalent to the structured physical activity. Gender discrimination has been described in literature but not extensively, but it is visible in context of a medical research which has been carried out mostly on men (70kg, white males as norm) neglecting morphological differences between males and females. Often primary health visit goes by without asking questions specific for women (pap-smear, breast examination, hormonal imbalance, etc)³³. It is true that in Croatia, within primary health care plan, every woman in theory is covered by gynecologist separately³⁴, although many of women do not exercise that service in

practice. That does not exclude these questions in quality approach by GP, especially knowing reality of usage of that service.

Communication between patient and doctor could be the core problem in lack of advising and one of the explanations of our results. Many studies state that GPs self report inadequate communication skills^{10,17}. Pavleković et al.³⁵ did extensive study on GPs individual-based nutrition communication strategies in Croatia and concluded that GPs considered smoking and alcohol as more important public health issues than inappropriate nutritional habits and physical activity and that main obstacle in individual-based communication in daily work is lack of time, lack of incentives, lack of knowledge and lack of family approach in nutrition consultation. On the other hand Lazic et al.¹¹ found that medical education in small groups proved its efficiency in treating obese patients in GP practice in program that lasted for three years in city of Varaždin, Croatia. Beside communication skills and doctor's ability to help their patients feel enabled to act on advice, important reason for lack of advising is assumption that patients were not motivated to change lifestyle, along with personal GPs beliefs, what is the most important problem, as oppose to the evidence based medicine approach³⁶. One of the possible contexts for explanation of our results could be gender of physician and patient, it has been described that efficiency and level of the conversation about the symptoms and disease has been better when patient and doctor were of the same gender³⁷.

On the other hand our results show strong influence of the family and other health care workers. Following the reported problem of lack of family approach in nutrition consultation reported on national level³⁵, results of study in our three counties, indicate great potential of family as setting for promotion of healthy lifestyle. The recognition of the problem and the consequences is visible from the fact that family is advising the most, the youngest age groups both symptom free and those with symptoms. Family is setting for acquiring good or bad health behavior and its influence should be exploited in health promotion. It has been described that 65% to 85% of various diseases and conditions are taken care in the family using experience acquired knowledge, without intervention from health care workers³⁸.

Furthermore, our results indicate that other health care workers also have important role in advising about lifestyle changes. This could be explained by easier access and absence of any payment. Although not separately stated in questionnaire, most probably most of advices give pharmacists to whom the access is easiest, and field nurses. Institution of field nurses is particularly valuable, because they help and advice, voluntarily, more people than only those covered by GP referral. In most cases when visiting patients in the villages or some remote neighborhoods even other people gather in the patient's house and get blood pressure or glucose measurements

or some other advice for free. Good example of community help is institution of visiting housekeepers, women who take care of elderly people who live alone often in villages and who can not completely take care of themselves. They bring food and other goods, clean, make sure medicines are taken, and make company couple of times a week or as needed. This program started as pilot by Ministry of health and social welfare³⁹ and now it is implemented in some counties in Croatia. This could be excellent support for visiting nurses, GPs and primary health sector, because they could, if educated well, serve as additional bridge between population and implementation of medical advices.

The fourth category who gives advice is someone else which we assumed are the various media. Our results indicate that they fill the void where other categories fail, especially with the problem of physical activity. They tend to promote physical activity to the youngest age group, and to the individuals who are symptoms free (normal blood pressure and normal BMI). The GPs failure to counsel younger population and disease-free adults could be missed opportunity for avoidance of various preventable states and diseases. In general media like TV or written like newspapers or various magazines for women, that, are easily available, could be excellent source of information and serve as additional health promotion and health educational material. They can bring the information to the settings where cultural, or some other subjective or objective obstacles, discourage women to turn directly to the medical service¹⁸, given the fact that public health community positively influence and educate journalists.

Conclusion

Many objective and subjective reasons influence application of preventive programs such a lifestyle changes within the GP visits in primary health care. But there are many other subjects in the communities that can complement GPs work and fill the gaps between the patients, health care system and healthy living habits. In order to create and develop such a heterogeneous network approach to training, various programs and activities, has to be holistic, taking into account all specific gender and regional characteristics that could range from geography to the culture. Well targeted health education and health promotion could deduce risk factors to the minimum. Still, there is certain doubt that many public health recommendations will remain without results as long as women do not have enough power on political, informational, social, economical and health care scene.

Acknowledgements

Displayed results were obtained from data collected through the project no 108-1080135-0264, funded by Croatian Ministry of Science, Education and Sports.

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TKO OSNAŽUJE ŽENE KA ZDRAVIJEM NAČINU ŽIVOTA?

PRIMJER IZ ZAPADNE HRVATSKE

SAŽETAK

Studija istražuje tko od četiri kategorije (liječnici, ostali zdravstveni radnici, obitelj, netko drugi) najčešće savjetuje žene o promjeni životnih navika (pušenje, prehrana, fizička aktivnost). Analizirani su i specifični parametri koji su značajni za pojavnost kardiovaskularnih bolesti: dob, sistolički tlak i indeks tjelesne težine (ITM). Uzorak je dio sveobuhvatne Hrvatske zdravstvene ankete, a sastojao se od žena iz Primorsko-goranske, Istarske i Ličko-senjske županije. Rezultati upućuju na malen broj savjeta koji se daju u primarnoj zdravstvenoj zaštiti u sve tri županije. Liječnici savjetuju najviše o prehranbenim navikama, dok obitelj i drugi zdravstveni radnici savjetuju o pušenju i prehrani i to najmlađu dobnu skupinu. Kategorija netko drugi, za koju se pretpostavlja da su mediji, najviše savjetuje o fizičkoj aktivnosti i to najmlađu dobnu skupinu kao i žene bez izraženih simptoma (normalan tlak i ITM). Izostanak savjeta prema najmlađoj dobnoj skupini i ženama bez simptoma, od strane liječnika može biti propuštena prilika u prevenciji nekih stanja i bolesti. Osim liječnika i drugi zdravstveni radnici zajedno uz obitelj i medije mogu ispuniti praznine u komunikaciji između pacijenata i zdravstvenog sustava. Ipak da bi se stvorila, i da može funkcionirati tako heterogena mreža, edukaciji, smjernicama i djelatnostima potrebno je potrebno je pristupiti sveobuhvatno uzimajući u obzir rodne i regionalne specifičnosti. Dobro usmjerena zdravstvena edukacija može smanjiti faktore rizika na minimum.