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RESEARCH
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HEALTH SELF-PERCEPTION OF PRIMARY CARE USERS

Autopercepção de saúde de usuárias da atenção primária

Auto-percepción de salud de los usuarios de atención primaria

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ABSTRACT

Objective: To determine the self-rated health of primary care users and to verify the association with socioeconomic and clinical factors and experience of violence. **Methods:** epidemiological, analytical, cross-sectional study with 991 women in 26 Basic Units of Vitória, Espirito Santo. Socioeconomic, clinical, health perception, and life-threatening experiences of intimate partner violence were used in data analysis. Poisson regression test for multivariate analysis was used to obtain the prevalence ratios, and the adjustment of variables was performed by the backward method, based on the hierarchical model. **Results:** women aged 40 years and over, non-white, with education of up to four years, evangelical and without paid work, more often perceive health negatively. **Conclusions:** socioeconomic, clinical and experience characteristics of intimate partner violence may contribute to negative perception of health.

Descriptors: Epidemiology, Perception, Women's health, Violence, Socioeconomic factors.

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RESUMO

Objetivo: Determinar a autopercepção de saúde de usuárias da atenção primária e verificar a associação com fatores socioeconômicos, clínicos e experiência de violência. **Métodos:** estudo epidemiológico, analítico, do tipo transversal realizado com 991 mulheres em 26 Unidades Básica de Vitória, Espirito Santo. Variáveis socioeconômicas, clínicas, de percepção de saúde, e, as experiências de violência praticada pelo parceiro íntimo ao longo da vida foram utilizadas nas análises dos dados. Teste de Regressão de Poisson para análise multivariada foi utilizada para obtenção das razões de prevalência, sendo o ajuste das variáveis realizado pelo método tipo backward, tendo por base o modelo hierárquico. **Resultados:** mulheres com 40 anos ou mais, não brancas, com escolaridade de até quatro anos, evangélicas e sem trabalho remunerado percebem mais frequentemente a saúde negativamente. **Conclusões:** características socioeconômicas, clínicas e de experiência de violência por parceiro íntimo podem contribuir para percepção negativa da saúde.

Descritores: Epidemiologia, Percepção, Saúde da mulher, Violência, Fatores socioeconômicos.

RESUMEN

Objetivo: Determinar la salud autoevaluada de los usuarios de atención primaria y verificar la asociación con factores socioeconómicos y clínicos y la experiencia de violencia. **Métodos:** estudio epidemiológico, analítico, transversal, con 991 mujeres en 26 unidades básicas de Vitória, Espirito Santo. En el análisis de los datos utilizaron variable socioeconómicas, clínicas, de percepción de la salud y que amenazan la vida de la violencia de la pareja. La prueba de regresión de Poisson para el análisis multivariado utilizó para obtener las tasas de prevalencia, y el ajuste de las variables se realizó mediante el método hacia atrás, basado en el modelo jerárquico. **Resultados:** mujeres de 40 años y más, no blancas, con educación de hasta cuatro años, evangélicas y sin trabajo remunerado, con mayor frecuencia perciben la salud negativamente. **Conclusión:** las características socioeconómicas, clínicas y de experiencia de la violencia de pareja pueden contribuir a percepción negativa de la salud.

Descriptores: Epidemiología, Percepción, Salud de la mujer, Violencia, Factores socioeconómicos.

INTRODUCTION

The majority of the Brazilian population are women (50.77%) and they are the main users of the Unified Health System (SUS). Studies indicate that they live longer than men, however, they are more vulnerable to certain diseases and health problems, since the causes of deaths are more related to the situation of discrimination in society than to biological factors.[1]

In Brazil, women's health was incorporated into national health policies in the first decades of the 20th century. Initially, these policies were limited to issues related to pregnancy and childbirth, in other words, they had limited vision of women, based on their biological specificity and on their social role as mother, responsible for raising, educating and caring for the health of their children and other family members.[1]

In the 80s, the Program for Integral Attention to Women's Health (PAISM) was launched, having as a pillar the commitment to the implementation of health actions that contribute to the guarantee of women's human rights and reduce morbidity and mortality from preventable causes. The focus of this policy is aimed at the needs of women, which included educational, preventive, diagnostic, treatment and recovery actions, encompassing assistance to women not only in prenatal care, childbirth and the puerperium, but also with actions in the climacteric, family planning, ensuring comprehensive care and not only focusing on the pregnancy-puerperal cycle.[2]

In this context, the approach to self-rated health becomes of great relevance, considering that total attention to health care is complex and multidimensional. [3] The analysis of the determinants of self-rated health becomes important, as it modulates these factors it means changing the self-perception of health, being able to change the morbidity and mortality of this population.[4]

Multiple factors can influence the perception of health of individuals, it is important to notice that subjects with different socio-cultural conditions experience a multiple perception of health.[3,5] It stands out that the experience of directly health of victims, which can generate trauma and disability, causing damage to physical, mental, emotional well-being and, in many cases, leading to death.[6] Studies of national and international scope prove that a considerable portion of women who have suffered some type of violence see their health status as regular or poor.[7,8]

Women in situations of violence tend to show more fragility and suffer permanent effects on their self-esteem and self-image, becoming insecure and more vulnerable to depression.[7,8] Finally, the experience of violence in the most varied dimensions translates into negative repercussions on the health of women, and also on the way they perceive their health. Therefore, violence has been considered a health issue of wide complexity, resulting in unfavorable outcomes of varying dimensions, being considered a public health problem of great relevance.[9]

Therefore, considering the magnitude of violence against women, and this implication by the lens of health, this study aimed to determine the self-perception health of primary care users and to verify the association with socioeconomic, clinical and experience factors of violence.

METHODS

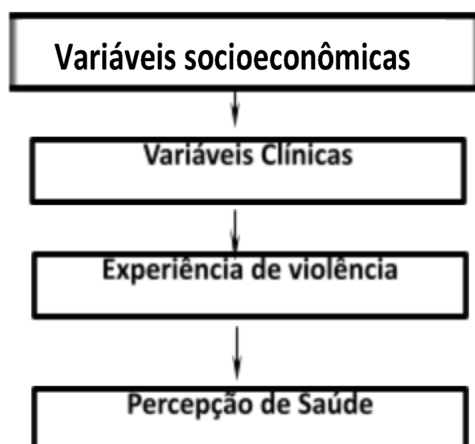
This is an epidemiological, analytical, cross-sectional study conducted with 991 women in 26 Basic Units (US) in Vitória, ES. The sample was calculated considering a 5% margin of error, 95% confidence level, and a prevalence of 50.0%. For the analysis of association with risk factors, were considered a 95% confidence level, 80% power and an exposed/ unexposed ratio of 1:1. An increase of 10% for possible losses and 30% for adjusted analyzes was also considered, with the sample size of 991 women. Participants were interviewed at the health unit in a private location with the presence of only the interviewer. The interviewers

and supervisors, all female, went through a training process to standardize the interview and apply the instruments.

In this study, the dependent variable considered was self-perception health. Such information was collected through the following research question: "Mrs., do you think your health is…?", with the following options: satisfactory (excellent/good) or unsatisfactory (regular/weak or very weak). To collect the independent variables, a standardized instrument was developed containing socioeconomic information: age (20-39 and 40-59 years); self-reported skin color (as recommended by the Brazilian Institute of Geography and Statistics - IBGE - stratified in white and non-white; years of study (up to 04; 5-8; 9 or more); marital status (with partner and without partner); monthly family income (up to 1000; 1001-1900; over 1900 reais); religion - Catholic (yes/no), evangelical (yes/no); and whether you currently have paid work (yes/no). As for the clinical variables collected: smoking (no; yes; ex-smoker), alcohol consumption (yes/no), and medical diagnosis of diabetes and hypertension (no; hypertension or diabetes; or hypertension and diabetes). The experience of violence was assessed through the application of the World Health Organization[10] (OMS) which consists of 13 questions related to the violence practiced by the intimate partner, such as: psychological, physical and sexual. For the variable history of violence practiced by the intimate partner in life, the following categories were considered (no; one type of violence; two types of violence or three types of violence).

The data were analyzed using the STATA 13.0 program and presented in descriptive form using tables with absolute and relative frequencies and confidence intervals. The bivariate analysis was performed using the Chi-Square test. The multivariate analysis was performed using Poisson Regression with robust variance. The entry in the model happened with $p < 0.20$, and the permanence in the model with $p < 0.05$. The adjustment of the variables was performed using backward selection, considering the hierarchical model shown in **figure 1**.

Figure 1 - Hierarchical model of the relationships between risk factors for the health perception outcome.

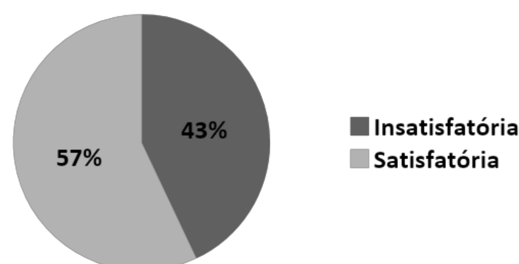


The study was approved by the Ethics Research Committee of the Federal University of Espírito Santo (Parecer 470.744/2013).

RESULTS AND DISCUSSION

Were interviewed 991 women. As for the perception of health (N: 565; P: 57.0%; 95% CI: 53.7-59.9), perceived their health as satisfactory, while (N: 426; P: 43.0%; 95% CI: 40.1-46.3) perceived their health as unsatisfactory (Figure 2).

Figure 2 – Prevalence of health perceptions of primary care users. Vitória, ES, March to September 2014.



It is notice that most of the participants are in the age group of 20 to 39 years (59.6%), declare themselves to be non-white (78.3%), have nine or more years of study (69.4%), live with a partner (74.0%), report being evangelical (56.0%), have a family income above R$ 1,900.00 per month (54.6%) and have paid work (60.4%). As for the clinical characteristics, it is noted that 721 (72.7%) and 642 (64.8%) women deny smoking and alcohol consumption, respectively. The medical diagnoses of arterial hypertension or diabetes was referred by 200 (20.2%) women, and about 49 (5.0%) women have diabetes and hypertension concomitantly (**Table 1**).

Table 1 shows the bivariate analysis of health perception according to socioeconomic, clinical and life experience characteristics. There are higher frequencies of unsatisfactory perception of health among women aged 40 years or older, non-white, who have a partner, with up to four years of study, total income of up to R$ 1000 reais per month, without paid work, diagnosed with hypertension and diabetes, and who experienced the three types of violence (psychological, physical and sexual) ($p < 0.05$).

Table 1: Prevalence of unsatisfactory health perception, according to socioeconomic, clinical characteristics and experience of violence in life. Vitória, ES, March to September 2014.

Variable	N	%	Unsatisfactory Perception		
Socioeconomic			%	95% CI	p-value
Age (years)					0,004
20-39	591	59,6	39,4	35,5-43,4	
40 or older	400	40,4	48,7	43,9-53,7	
Skin color					0,005
White	215	21,7	34,9	28,8-41,5	
Non-white	776	78,3	45,5	42,0-49,0	
Schooling level					0,000*
Up to 4	112	11,3	65,2	55,9-73,4	
5-8	191	19,3	51,3	44,2-58,4	
9 or more	668	69,4	37,3	33,8-41,0	
Marital status					0,168
With a partner	733	74,0	44,5	40,9-48,1	
Without a partner	258	26,0	39,5	33,7-45,6	
Catholic					0,074
No	438	51,1	45,7	41,0-50,4	
Yes	419	48,9	39,6	35,0-44,4	
Evangelical					0,000
No	377	44,0	34,7	30,0-39,7	
Yes	480	56,0	49,0	44,5-53,4	
Monthly Family income					0,000*
Up to 1000	194	19,6	53,6	46,5-60,5	
1001-1900	256	25,8	47,7	41,6-54,0	
Above 1900	541	54,6	37,3	33,4-41,5	
Paid work					0,003
No	392	39,6	49,0	44,0-53,9	
Yes	599	60,4	39,4	35,6-43,4	
Clinical					
Smoking					0,052
No	721	72,7	40,9	37,4-44,6	
Yes	109	11,0	51,4	42,0-60,5	
Ex-smoker	161	16,3	47,8	40,2-55,6	
Alcoholic consumption					0,150
No	642	64,8	44,9	41,0-48,7	
Yes	349	35,2	40,1	35,1-45,4	
Diabetes and Hypertension					0,000
No	742	74,9	35,7	32,2-39,3	
Diabetes or hypertension	200	20,2	62,0	55,1-68,5	
Diabetes and hypertension	49	4,9	79,6	65,9-88,7	
Life Experience					
Physical, sexual and psychological violence in life					0,000*
No	370	37,3	33,0	28,4-37,9	
One type of violence	232	23,4	41,0	34,8-47,4	
Two types of violence	261	26,3	51,7	45,6-57,8	
Three types of violence	128	12,9	59,4	50,6-67,6	

*Trend p value.

Table 2 shows crude and adjusted prevalence ratios for the effects of socioeconomic, clinical variables and experiences of violence on the unsatisfactory perception of health. After the adjustment, it is noted that the unsatisfactory perception was associated with age, skin color, education, evangelical religion, paid work, diagnosis of diabetes and/or hypertension and the experience of violence committed by the partner through life ($p < 0.05$).

Women aged 40 older and non-white have 1.19 (95% CI: 1.01-1.39) and 1.28 (95% CI: 1.04-1.58) times more often with poor health perception, respectively. Women with up to four years of schooling have a 59.0% higher prevalence of unsatisfactory perception of their health when compared to those with higher schooling (nine years or more of study). Still, evangelical women and those without paid work perceive their health as 1.37 and 1.24 times more frequently in a negative way ($p < 0.05$).

Having a diagnosis of diabetes or hypertension represents an increase in the perception of poor health of 62.0%. As for those who have both problems, the negative perception of health is twice as high when compared to those who do not have these diseases.

Women who throughout their lives experienced violence, committed by an intimate partner, of the psychological, physical and sexual type, showed an increase of 47.0%, in the prevalence of unsatisfactory perception of health.

Table 2- Crude and adjusted analysis of the effects of socioeconomic, behavioral variables and life experience on poor health perception. Vitória, ES, March to September 2014.

Socioeconomic variables	Gross PR	95% CI	p -value	Adjusted PR	95% CI	p-value
Age (years)			0,003			0,033
20-39 years	1,0			1,0		
40 years or older	1,24	1,07-1,42		1,19	1,01-1,39	
Skin color			0,009			0,021
White	1,0			1,0		
Non-white	1,30	1,07-1,59		1,28	1,04-1,58	
Schooling level			0,000			0,000
to 4	1,74	1,16-1,63		1,59	1,15-1,62	
5-8	1,37	1,48-2,07		1,26	0,65-0,98	
9 or more	1,0			1,0		
Marital status			0,178			0,451
With a partner	1,12	0,95-1,34		1,08	0,89-1,30	
Without a partner	1,0			1,0		
Catholic			0,075			0,295
No	1,0			1,0		
Yes	0,87	0,74-1,01		1,12	0,91-1,37	
Evangelical			0,000			0,000
No	1,0			1,0		
Yes	1,41	1,19-1,66		1,37	1,16-1,62	
Monthly Family income			0,000			0,178
Up to 1000	1,44	1,08-1,51		1,21	0,99-1,49	
1001-1900	1,28	1,21-1,70		1,07	1,03-1,40	
Above 1900	1,0			1,0		
Paid work			0,003			0,005
No	1,24	1,08-1,43		1,24	1,07-1,44	
Yes	1,0			1,0		
Smoking			0,041			0,652
No	1,0			1,0		
Yes	1,26	1,03-1,54		1,11	0,88-1,40	
Ex-smoker	1,17	0,97-1,40		1,06	0,88-1,29	

Alcoholic consumption			0,357			--
No	1,0			--		
Yes	0,95	0,85-1,06		--	--	
Diabetes and Hypertension			0,000			0,000
No	1,0			1,0		
Diabetes or hypertension	1,74	1,50-2,01		1,62	1,37-1,93	
Diabetes and hypertension	2,23	1,88-2,65		2,0	1,67-2,55	
Life Experience						
Physical, sexual and psychological violence in life						0,000
No	1,0			1,0		
One type of violence	1,24	1,00-1,54		1,14	0,92-1,42	
Two types of violence	1,57	1,30-1,89		1,49	1,23-1.82	
Three types of violence	1,80	1,47-2,21		1,47	1,18-1,83	

This study aimed to identify the health perception of primary care users in the city of Vitória, Espírito Santo. It appears that 57.0% of women perceived their health as satisfactory, while 43.0% unsatisfactory. A study carried out with adults showed that among women the negative perception of health was 30.3% .[11] Another survey conducted with young adults living in Belo Horizonte pointed out that 20.3% of women perceived their health negatively.[12]

In the present study, the highest prevalence of unsatisfactory health perception was found among women aged 40 years or older (PR: 1.19; 95% CI: 1.01-1.39), when compared to younger women (20 to 39 years). This result is similar to other surveys found on literature, in which, the older a woman is, the more likely a worse self-perception of health.[13]

It is well established that, as one gets older, the general health status decreases and, consequently, also the self-assessment of health.[14] This association is consistent since with the advancing age, individuals tend to have more health problems, such as functional disabilities and an increase in chronic diseases.[15]

The present study highlights a higher prevalence of unsatisfactory health perception among non-white women (PR: 1.28; 95% CI: 1.04-1.58). According to a study conducted with women registered in health units in Minas Gerais, a greater negative perception of health was observed among non-white women.[16] A birth cohort study carried out in Pelotas, RS, shows that individuals of white skin color in general have better social and economic conditions, have greater access to health services and have a lower prevalence of certain negative health-related behaviors.[17]

Another relevant finding was the higher occurrence of unsatisfactory assessment of health status among women with less education (PR: 1.59; CI9 %%: 1.15-1.62). This association was shown in a study where the prevalence ratio of poor health perception in women with schooling between 0-8 years was 1.73 times higher compared to the group with higher education.[16] In the same sense, a study in Rio Grande do Sul shows the low level of education associated with the negative perception of health.[18] Certainly, those with a higher level of education tend to have more access to social opportunities throughout their lives, such as access to health services, information and to adopt better living conditions.[19]

In this study, evangelical women perceived their health 1.37 times more negatively. A study with elderly people in Campinas revealed that the highest prevalence of positive health was found in individuals who reported not having a religion.[19] However, it is important to understand the positive influence of religiosity and spirituality in supporting feelings of guilt, anger and anxiety. Beliefs can mobilize extremely positive energies, which strengthen the potential to deal with limitations. Faith can intervene favorably in the course of the disease and its effects on life.[20]

The negative perception of health status was associated with the variable paid work. The absence of paid work increases the unsatisfactory perception of health by 24.0%. A survey showed that negative self-perceived health was 37% higher among people who did not work.[18] Another study showed that 46.3% of women who do not have formal work have a negative perception of health.[16] It is worth notice that work is considered a form of social insertion, so that being without work can interfere with self-esteem, affecting the ability personal/professional.

The results of this study indicate that the presence of chronic diseases (diabetes and/or hypertension) is significantly associated with a negative perception of health status. A study conducted with women in menopause showed that about 55.0% of women with high blood pressure and 63.0% of women with diabetes perceived their health in a negative way.[16] In the same sense, a study with quilombolas, showed that the presence of chronic diseases was associated with negative self-perception of health.[21] Chronic diseases can significantly affect the quality of life and limit activities from those considered basic for the individual, such as work and leisure, as well as contributing to the worst classification of their health.[3,22]

The literature points out that the violence practiced by the partner reflects on physical, psychological and emotional problems, negatively influencing the integrity of women's health in a degrading, aggressive and destructive way.[7] In the present study, the highest prevalence of unsatisfactory perception stands out among women who have experienced violence by their intimate partners in life. In this context, in Iran, being a victim of sexual violence was associated with health problems such as depression, as well as poor self-rated health.[8] In another study, it was evidenced that suffering physical violence by an acquaintance reduces the probability of women self-perceiving their health status as good or very good.[23]

Among the limitations of the study, the studied population must be considered, first, which was composed

only of women assisted in primary care, which can lead to an overestimated result of prevalence of negative health perception, since the participants may be in the service in search of assistance to some health demand and thus perceive their health in a more unsatisfactory way compared to the general population. Another limitation that concerns its transversal character, which limits the results of the associations, due to the temporal relationship between the outcome under study and the analyzed exposures, however, the age and race variables do not fit this limitation, claiming to be important characteristics to be assessed in the perception of health.

CONCLUSIONS

The results of this study offer subsidies for understanding how much socioeconomic, clinical aspects and experiences of violence in life affect women's perception of health. Therefore, it is possible to conclude that older women, with low education, who do not have paid work and with a history of violence had a higher prevalence of unsatisfactory perception of their health.

In this sense, it is extremely important to recognize these factors and, in particular, the experience of violence by an intimate partner in order to contribute so that the service understands the real demands of care for women and thus promotes actions, with special attention to this most vulnerable group.

In addition, a low number of studies on the subject was observed in the literature, making it clear the need for more studies that relate the impacts of violence on health, especially on how this aspect of life is self-assessed.

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