



## THE RELATIONSHIP BETWEEN HEALTH PROMOTION LIFESTYLE AND TYPE OF DELIVERY IN REPRODUCTIVE AGED WOMEN IN AHVAZ, IRAN

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**Abstract:** Given the sensitive nature of pregnancy and childbirth and its impact on women's health this study was designed to investigate the relationship between health promotion lifestyle and type of delivery in reproductive aged women. This cross-sectional study was conducted on 1,200 reproductive aged women who were referred to 10 health centers in Ahvaz. Data were collected by demographic questionnaire and Health Promotion Lifestyle Profile 2 (HPLP2). Data analysis was performed with SPSS version 21 and chi-square test, Kruskal-Wallis test and logistic regression were used. The mean score of health promotion lifestyle score was  $135.59 \pm 23.85$ . Most of women had moderate lifestyle (67%). Health promotion lifestyle had significant association with female's education and occupation, Spouse's education and occupation ( $P < 0.001$ ). There was no significant association between health promotion lifestyle and age, duration of marriage and Spouse's age ( $p > 0.05$ ). Type of delivery had significant association with health promotion lifestyle ( $P < 0/001$ ) and caesarean section had the most negative impact on health promotion lifestyle (OR = 0.50, CI = 0.27 – 0.90,  $P = 0.023$ ). Based on the results of this study, health promotion lifestyle is related to the type of delivery in reproductive aged women. Therefore, appropriate educational programs recommended for improving women's health.

**Key words:** Health Promotion Lifestyle, Reproductive Age, Type of Delivery.

### INTRODUCTION

Women are half of the population, managers and coaches of families and community activists and their health constitute basic health of half the population, family and society (1). Women's health is also one of the indicators of development from the perspective of the United Nations because women due to physiological conditions associated with reproduction and its complications, are more vulnerable than men (2). Pregnancy and childbirth are periods of a woman's life that create a specific physical and psychological change (3). According to the WHO, maximum acceptable level for Caesarean section is 15% (4), despite this issue, the rate of cesarean is different in various parts of the world and is increasingly growing, So that in the last twenty years has increased from 15% to 25% (5). In Iran it was reported the incidence of cesarean section from 26% to 60% and even 90% in some private centers (6). The results of research have shown that more than 70% of women in Iran are seeking cesarean to unnecessary causes (7). In most women with cesarean delivery, surgery and increase the duration of hospitalization increased obstetric problems include infection, bleeding, thrombosis, pelvic injury and Caesarean wound complications (8). No event in human life requires rapid change in the way, role and performance as well as birth and arrival of a new baby to the family (9). Several studies have shown that pregnancy and after childbirth can cause changes in aspects of quality of life which include physical, psychological and social (10, 11).

Lifestyle during pregnancy has long lasting effects on the health of mother and child (12), So that an unhealthy lifestyle increases the risk of preterm delivery or low birth weight (13). Initial discussions on the lifestyle focused on diet, exercise, smoking and alcohol consumption, while today has changed understanding of lifestyle and its relationship to health. Lifestyle includes purpose of individuals, self-concept, feelings toward others and the person's attitude toward the world (14). Health promotion is the empowerment of individual in recognition of effective factors on individual and social health and the correct decision in choosing healthy behaviors as a result of compliance with healthy lifestyles (15), and includes behaviors which a person perform proper nutrition, regular exercise, avoidance of destructive behavior and substance abuse, protection from disasters, recognize the symptoms of disease in physical dimension, control of emotions and thoughts and cope with stress and mental problems in psychological dimension, independence, adaptability and reform interpersonal relationships in social dimension (16). Health promotion lifestyle is the multi-dimensional model of perception and self-motivated started actions that helps to sustain and enhance the health and prosperity (17) and explanatory the human tendency to excellence that leads to optimal well-being, personal development and the creative life and has six dimensions that including interpersonal relationships, health responsibility, spiritual growth or self-actualization, stress

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management, nutrition and physical activity (18). These behaviors are a major determinant of health that known as the underlying cause of many diseases and health promotion and disease prevention is directly associated with these behaviors (19). Studies done on the health-promoting lifestyle have shown that many factors related to health promotion lifestyle such as age, social support, marital status, education, occupation, spouse's occupation, race, perception of health, place of residence, self-esteem and cultural adaptation (20-25). Women in the postpartum period are faced with multiple physical and mental disorders that these problems have a major impact on health and quality of life and associated with the type of delivery (26-29). Almost 40% of pregnant women experience health problems during pregnancy or in the postpartum period and 15% of those suffering from serious long-term complications that sometimes accompany them for life (30). Type of delivery is one of the factors affecting health. High levels of elective caesarean section compared to the world average on the one hand and the limited number of studies about the relationship between health promotion lifestyles and type of delivery caused us to do this study aimed to investigate the relationship between health promotion lifestyle and type of delivery.

### MATERIAL AND METHODS

This cross-sectional study was designed to investigate the relationship between health promotion lifestyle and type of delivery. 1200 reproductive aged women, who were referred to 10 health centers in Ahvaz, were recruited. The subjects were recruited using multistage cluster sampling. Ahvaz was divided into 2 areas West and East, and then was selected 5 health center from each area. Ultimately participants were selected randomly through a number of records in health centers. Inclusion criteria included age 15-45 years, being married, having literacy, lack of drug addiction and the exclusion criteria included menopause, pregnancy, infertility, sleep disorder, breast-feeding women less than two months after their birth, the presence of spotting and bleeding, the presence of diseases such as diabetes mellitus and hypertension and previous history of mental disorders. At baseline, all participants signed a written consent. The data collection tools were included demographic questionnaire that including age, education, occupation, duration of marriage, type of last delivery, spouse's age, spouse's education and spouse's occupation and HPLP2 questionnaire. HPLP2 questionnaire consisted of 52 questions that were included 6 aspects self-actualization, health responsibility, interpersonal relationships, stress manage, exercise and nutrition. Each question had four options including never, sometimes, often and always

in which scored using Likert scale. Validity and reliability of this questionnaire was checked in Iran by Mohammadi Zaidi et al., (31), Participants were divided into three groups based on the life style score. The score 103 and less indicated poor lifestyle, score 155-104 indicated moderate lifestyle and score 156 and higher showed good lifestyle. Data analysis was performed with SPSS software version 21. Given that data distribution was not normal were used nonparametric tests. Kruskal-Wallis test was used to compare quantitative variables and Chi-square test for categorical variables and logistic regression for predictive factors of health promotion lifestyle and  $p < 0.05$  was considered significant.

### Findings

The mean score of health promotion lifestyle was  $135.59 \pm 23.85$ . More women had moderate lifestyle (67%). The good lifestyle group had older age and less duration of marriage and the moderate lifestyle group had the lowest age and the poor lifestyle group had the highest duration of marriage. The spouse's age had the highest mean in the poor lifestyle group and lowest mean in the moderate lifestyle group. Kruskal-Wallis test showed no significant difference between the groups in terms of age, spouse's age and duration of marriage ( $p > 0.05$ ). Most of the women with good lifestyle were employed and had university education and most of their spouses were employed and had university education. The most of poor lifestyle group were housewife and had primary education and most of their spouses were employed and had secondary education. Chi-square test showed significant differences between the three groups ( $p < 0.05$ ) (Table 1). The mean score of health promotion lifestyle and its dimensions were higher in good lifestyle group and lower in poor lifestyle group. The highest mean was related to health responsibility ( $35.11 \pm 7.81$ ) and self-actualization ( $31.94 \pm 6.26$ ) and the lowest mean was related to exercise ( $11.89 \pm 5.34$ ). Kruskal-Wallis test showed significant differences between the three groups ( $p < 0.05$ ). (Table 2) Also Chi-square test showed a significant relationship between health promotion lifestyle and type of last delivery in reproductive aged women ( $p < 0.05$ ) (Table 3). The chance of women with primary education have desirable lifestyle, compared with women with a university education was 22% (OR = 0.22, CI = 0.09 – 0.52,  $P = 0.001$ ). The chance of women with secondary education have desirable lifestyle, compared with women with a university education was 18% (OR = 0.18, CI = 0.09 – 0.39,  $P < 0.001$ ). As well as the chance of women with high school education have desirable lifestyle, compared with women with university education was 54% (OR = 0.54, CI = 0.30 – 0.98,  $P = 0.045$ ). The chance of women who had cesarean delivery have desirable lifestyle compared to women

who had no birth was 50% (OR = 0.50, CI = 0.27 – 0.90, P = 0.023). Women who had employed spouses 3 times higher than women who had unemployed spouses, had desirable lifestyle (OR = 2.84, CI = 1.40 – 5.76, P = 0.004). The chance of women who their spouses had primary education have desirable lifestyle, compared women who their spouses had university education was 30%

(OR = 0.30, CI = 0.12 – 0.77, P = 0.012). The chance of women who their spouses had secondary education have desirable lifestyle, compared women who their spouses had university education was 28% (OR = 0.28, CI = 0.14 – 0.55, P < 0.001) (Table 4).

**Table 1:** demographic characteristics in different groups of lifestyle

groups Variable	Poor lifestyle n=161	Moderate lifestyle n=793	Good lifestyle n=246	P value
<b>Mean ± SD</b>				
Age (year)	30.68 ± 8.59	30.51 ± 7.14	31.63 ± 5.99	0.796
Spouse's Age (year)	35.47 ± 10.12	34.63 ± 8.15	6.24 ± 34.88	1.000
Duration of Marriage (year)	10.33 ± 8.47	8.67 ± 7.11	7.96 ± 5.55	0.266
<b>n (%)</b>				
<b>Occupation</b>				
Employed	7 (4.3)	206 (26)	139 (56.5)	<0.001
Housewife	154 (95.7)	587 (74)	107 (43.5)	
<b>Education</b>				
primary	74 (46)	63 (7.9)	4 (1.6)	<0.001
secondary	54 (33.5)	166 (20.9)	10 (4.1)	
High school	25 (15.5)	233 (29.4)	75 (30.5)	
university	8 (4.9)	331 (41.7)	157 (63.9)	
<b>Spouse's occupation</b>				
Employed	138 (85.7)	760 (95.8)	245 (99.6)	<0.001
Unemployed	23 (14.3)	33 (4.2)	1 (0.4)	
<b>Spouse's education</b>				
primary	41 (25.5)	46 (5.8)	2 (0.8)	<0.001
secondary	73 (45.3)	151 (19)	12 (4.9)	
High school	28 (17.4)	299 (37.7)	72 (29.3)	
university	19 (11.8)	297 (37.5)	160 (65)	

Chi-square test for categorical variables and Kruskal-Wallis test for numerical variables.

**Table 2:** Compare Mean of total health promotion lifestyle and its subscales in three groups of lifestyle

Groups variable	Poor lifestyle n=161	Moderate lifestyle n=793	Good lifestyle n=246	Total mean	P value
<b>Mean ± SD</b>					
Self-actualization	22.86 ± 3.28	31.69 ± 4.84	38.69 ± 3.02	31.94 ± 6.26	< 0/001
Health responsibility	23.55 ± 3.18	34.88 ± 5.93	43.42 ± 4.57	35.11 ± 7.81	< 0/001
Interpersonal relationship	15.69 ± 3	21.74 ± 3.84	27.82 ± 3.90	22.14 ± 5.01	< 0/001
Stress management	9.82 ± 1.81	13.21 ± 2.67	17.22 ± 3.41	13.58 ± 3.49	< 0.001
exercise	7.19 ± 0.81	11.15 ± 4.37	17.35 ± 5.57	11.89 ± 5.34	< 0.001
nutrition	17.32 ± 3.17	20.83 ± 3.77	23.3 ± 3.41	20.87 ± 4.01	< 0.001
Total lifestyle	96.46 ± 6.64	133.51 ± 13.78	167.87 ± 8.72	135.59 ± 23.85	< 0.001

**Table 3:** Comparing type of delivery in different groups of lifestyle Chi-square test

Groups variable	Poor lifestyle n=161	Moderate lifestyle n=793	Good lifestyle n=246	P value
Type of last delivery	<b>n (%)</b>			< 0.001
vaginal	98 (60.9)	405 (51.1)	85 (34.5)	
cesarean	44 (27.3)	332 (41.9)	135 (56)	
Without delivery	19 (11.8)	56 (7)	26 (10.5)	

**Table 4:** Multivariate logistic regression analysis for factor associated with health promotion lifestyle, Bold indicates  $p < 0/05$ .

variable		B	P-value	OR	CI 95%	
					Lower	Upper
Occupation (housewife base)	Employed	0.37	0.076	1.45	0.96	2.19
	Primary	-1.50	0.001	0.22	0.09	0.52
Education (university base)	secondary	-1.66	$< 0.001$	0.18	0.09	0.39
	High school	-0.60	0.045	0.54	0.30	0.98
Type of last delivery (without delivery base)	Vaginal	-0.50	0.092	0.60	0.33	1.08
	cesarean	-0.69	0.023	0.50	0.27	0.90
Spouse's occupation (unemployed base)	Employed	1.04	0.004	2.84	1.40	5.76
	primary	-1.18	0.012	0.30	0.12	0.77
Spouse's education (university base)	secondary	-1.25	$< 0.001$	0.28	0.14	0.55
	High school	0.11	0.659	1.12	0.67	1.87

## DISCUSSION

This study was conducted to investigate the relationship between health promotion lifestyles and the type of delivery in reproductive aged women. Most of the subjects had moderate lifestyle. Yarahmadi *et al.*, (24), Mirghafourvand *et al.*, (23), Bahar *et al.*, (32) and Ashrafye Hafez *et al.*, (33) reported similar results in their studies. The highest score was related to health responsibility and self-actualization that indicating the reproductive aged women are able to identify and control the factors affecting their health and have the potential to maximize their health. Self-actualization or spiritual health is an important aspect of human health that gives life purpose and direction, and harmonious relationship between human and his God, society and the environment. Therefore the high level of self-actualization the confirmed the impact of religion and culture on health promotion behaviors. Our finding was similar to the results of Ghorbani *et al.*, (34), and in other studies, the highest score was given to the self-actualization (25, 35, 36). The lowest score was related to exercise. The Mirghafourvand *et al.*, Yarahmadi *et al.*, Ballard and Beser *et al.*, studies had similar results with our study (23, 24, 36, 37). Lack of exercise as a challenge in all countries is a risk factor for many diseases is. Lack of exercise as a challenge in all countries and is a risk factor for many diseases because it has been proven that physical activity has positive effects on health. So should review the causes of the lack of physical activity in women and is planning educational interventions and good practices to promote physical activity. Unlike our study, in Lee *et al.*, study was the lowest score related to the health responsibility (25). The cause of this problem is that women in South-East Asia typically belong to socially excluded groups and do not have adequate access to health care also they have been influenced by the traditions of the continued generation and childbearing and do not consider their health as an important issue. Our study showed that female education was one of the factors affecting lifestyle. The results of

Mirghafourvand *et al.*, Bahar *et al.*, Ballard, Pirinice *et al.*, and Sehhati *et al.*, studies confirmed our finding (23,32,36,38,39). Also spouse's occupation is an effective factor on health promotion lifestyle which focuses on the impact of economic conditions on health, this means that women who had working spouses, have more access to health care and had more facilities for housing and adequate nutrition and living in safer areas, thus better opportunity to have health promoting behaviors. The results of Mirghafourvand *et al.*, and Sehhati *et al.*, studies were consistent with the results of our study (23, 39). In our study spouse's education was other effective factor in health promotion lifestyle. In fact, the spouse's education as a factor in the increased awareness of health-related behaviors and attempt to perform these behaviors. The education of woman and the spouse's education is considered related to health outcomes through the impact on lifestyle behaviors (e.g. diet and exercise) values and the capacity to solve problems. Our results were consistent with other studies (23, 39). In our study previous type of delivery was effective on health promotion lifestyle so that the women who had cesarean delivery had poorer lifestyle. This may be due to the health of women who had cesarean delivery due to complications of cesarean affected. The strengths of this study are that it is new. Our study had several limitations. First, this study cannot determine causality, so prospective studies are required in this regard to achieve more accurate results. Second, individual, cultural, social and psychological characteristics differences can affect how to answer questions that will affect the results of research and these factors are outside the control of the researcher.

## CONCLUSION

The present study showed that health promotion lifestyle is related to type of delivery in reproductive aged women. Women in our society tend to give birth by caesarean section and they believe it as the optimal delivery method with fewer side effects

and also cesarean delivery have the most negative impact on health promotion lifestyle. Therefore, health managers and planners can do the necessary actions to create Positive view of women toward vaginal delivery through appropriate educational program and thereby to improve women's health and quality of life.

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