

Chronic diseases among women of reproductive age in primary care: prevalence and associated factors

Doenças crônicas entre mulheres em idade reprodutiva na atenção primária: prevalência e fatores associados

Enfermedades crónicas en mujeres en edad reproductiva en atención primaria: prevalencia y factores asociados

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ABSTRACT

Objective: To analyze the prevalence and associated factors with chronic diseases among women of reproductive age in primary health care.

Method: Cross-sectional study conducted with 397 women of reproductive age living in northern Paraná, Brazil. Data were collected from July 2019 to September 2020. The Women's Clinical Record was used to collect sociodemographic data, risk behaviors, diagnosis of chronic diseases and medication use. Chi-Square test was performed for association analysis, and Logistic Regression estimating *Odds Ratio* and 95% confidence intervals.

Results: The prevalence of chronic diseases among women of reproductive age was 38.53% and the associated factors were: age group from 31 to 40 years old (OR=3.67; p=0.001) and from 41 to 49 years (OR =9.7; p=0.001), incomplete high school education (OR= 2.7; p=0.001), obesity (OR= 2.25; p=0.001) and smoking (OR=2.23; p=0.001).

Conclusion: Age at the end of the reproductive phase, obesity and smoking were associated with the presence of chronic diseases. Knowledge of these factors can assist in screening, monitoring and health education actions provided to women of childbearing age.

Descriptors: Nursing. Reproductive health. Women's health. Primary health care. Chronic disease.

RESUMO

Objetivo: Analisar a prevalência e fatores associados às doenças crônicas entre mulheres em idade reprodutiva na atenção primária à saúde.

Método: Estudo transversal realizado com 397 mulheres em idade reprodutiva residentes no norte do Paraná, Brasil. Os dados foram coletados no período de julho 2019 a setembro 2020. Utilizou-se a Ficha Clínica da Mulher para coleta de dados sociodemográficos, comportamentos de risco, diagnóstico de doenças crônicas e uso de medicamentos. Foram realizados os testes Qui-Quadrado para análise de associação, Regressão Logística estimando *Odds Ratio* e intervalos de confiança 95%.

Resultados: A prevalência de doenças crônicas entre mulheres em idade reprodutiva foi de 38,53% e os fatores associados foram: faixa etária de 31 a 40 anos (OR=3,67; p=0,001) e de 41 a 49 anos (OR=9,7; p=0,001), ensino médio incompleto (OR= 2,7; p=0,001), obesidade (OR= 2,25; p=0,001) e tabagismo (OR=2,23; p=0,001).

Conclusão: Foram associados à presença de doenças crônicas a idade no final da fase reprodutiva, a obesidade e o tabagismo. O conhecimento desses fatores pode auxiliar nas ações de rastreio, monitoramento e de educação em saúde prestadas às mulheres em idade fértil.

Descritores: Enfermagem. Saúde reprodutiva. Saúde da mulher. Atenção primária à saúde. Doença crônica.

RESUMEN

Objetivo: Analizar la prevalencia y los factores asociados a las enfermedades crónicas entre mujeres en edad reproductiva en la atención primaria de salud.

Método: Estudio transversal realizado con 397 mujeres en edad reproductiva residentes en el norte de Paraná, Brasil. Los datos se recolectaron desde julio de 2019 a septiembre de 2020. Se utilizó la Historia Clínica de la Mujer para recolectar datos sociodemográficos, conductas de riesgo, diagnóstico de enfermedades crónicas y uso de medicamentos. Se realizó prueba de Chi-Cuadrado para análisis de asociación, Regresión Logística estimando *Odds Ratio* e intervalos de confianza del 95%.

Resultados: La prevalencia de enfermedades crónicas entre las mujeres en edad reproductiva fue de 38,53% y los factores asociados fueron: rango de edad de 31 a 40 años (OR=3,67; p=0,001) y de 41 a 49 años (OR =9,7; p= 0,001), educación secundaria incompleta (OR= 2,7; p=0,001), obesidad (OR= 2,25; p=0,001) y tabaquismo (OR=2,23; p=0,001).

Conclusión: La edad al final de la fase reproductiva, la obesidad y el tabaquismo se asociaron con la presencia de enfermedades crónicas. El conocimiento de estos factores puede ayudar en las acciones de detección, seguimiento y educación en salud brindadas a las mujeres en edad fértil.

Descriptores: Enfermería. Salud reproductiva. Salud de la mujer. Atención primaria de salud. Enfermedad crónica.

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■ INTRODUCTION

Chronic Non-communicable Diseases (NCDs) are multi-determined and result from a combination of non-modifiable risk factors, such as age, gender, and heredity, and modifiable behavioral factors, such as smoking, inadequate dietary patterns, excessive consumption of alcoholic beverages and sedentary lifestyle^(1,2).

These diseases account for more than half of deaths in Brazil, and in 2018 the mortality rate was 54.7%⁽²⁾. The increase in the prevalence of NCDs is influenced by the process of globalization, rapid urbanization, and social determinants of health that influence the care actions adopted and access to healthcare services⁽³⁾. The behavioral risk factors directly impact metabolism, which can trigger overweight/obesity, high blood pressure and, consequently, result in cardiovascular disease, stroke, cancer and other diseases^(2,4).

In low- and middle-income countries, including Brazil, NCDs are among the main causes of mortality among women due to significant changes in the global burden of diseases in recent decades^(5,6). During reproductive age, maternal health problems may occur, such as gestational diabetes and pregnancy-induced hypertension, which indicate an increased risk of future NCDs, warning about the importance of consistency in PHC services in monitoring these women, especially regarding changes in lifestyle^(7,8).

However, the management of NCDs is still not a priority on the women's health agenda, since the health actions and services offered still have a majority focus on diagnostic services and treatment of already established diseases, sexual and reproductive health and in the prevention and screening of cervical cancer and breast cancer⁽⁶⁾. Therefore, discussions on restructuring of women's health care through lines of care and service networks capable of addressing their comprehensive needs are necessary⁽⁷⁾.

Considering morbidity and mortality among women due to NCDs as an important public health problem, although some risk factors are already a consensus for the general population⁽⁹⁾, the analysis of these specifically among women allows the identification of causes that are sensitive to PHC and that should be valued in the services offered to this population segment. Given this, the following questions arise: What is the prevalence of chronic diseases among women of reproductive age attending primary health care services? What risk factors are associated?

The present study aimed to analyze the prevalence and associated factors with chronic diseases among women of reproductive age in primary health care.

■ METHOD

Descriptive, cross-sectional study, conducted in 11 health institutions in six municipalities in the 16th Health Region located in the northern state of Paraná, Brazil, whose care model is the Family Health Strategy (FHS). The study was distributed across eight Basic Health Units (BHU) in three municipalities, two Women's Clinics in two municipalities and a Health Center in one municipality. All health institutions are located in the urban area of the six selected municipalities.

Data collection took place from July 2019 to September 2020 and was conducted with 397 women of reproductive age (age group 18 to 49 years old).

The population considered was 111,658 women of reproductive age from 17 municipalities in the 16th Health Region in northern Paraná, according to data from the Department of Primary Care Information (*Departamento de Informações da Atenção Básica – E-SUS AB*). The sample selection aimed to cover the entire region geographically. A stratified, double-stage random sampling process was adopted, considering the number of women of reproductive age in each municipality and the size of the municipality (small: up to 10,000 inhabitants – 13 municipalities; medium: between 10,001 and 50,000 inhabitants – 02 municipalities; large: over 50,001 inhabitants – 02 municipalities), also taking into account logistical feasibility reasons. Thus, after stratifying the municipalities, six municipalities were randomly selected from the 16th HR.

Subsequently, the sample was randomized, stratified by the number of women of reproductive age in each municipality. The original sample size was determined with data from a 50% prevalence of the outcome, ensuring a sample with the maximum possible population, to control the level of error and confidence level. Considering an alpha of 5% and a power of 80%. Thus, a sample of 397 women was obtained, plus 10% to cover possible losses. The population of women interviewed in each municipality selected was proportional to the number of women registered in E-SUS AB and the average number of women attended in the institutions where the research took place.

The dependent variable of the study was the report of diagnosis of chronic diseases. The independent variables were sociodemographic characteristics (age, education, race/color, religion, marital status and occupation); description of vital signs, weight and height to determine the Body Mass Index (BMI); lifestyle/risk behaviors (smoking, alcoholism, drug use, physical activity); and continuous use of medications.

As inclusion criteria, women of reproductive age (18 to 49 years old) were eligible for the research, without restrictions

regarding ethnicity, education or social class and having previously been attended at least once in the last two years by an FHS team. Women under 18 years of age were excluded, as well as women who, at the time of the research, were not in a physical condition to participate in the study, such as having undergone a previous procedure and with limited disability due to the diagnosis and treatment of diseases at the time. Therefore, 19 women were excluded from the research: seven due to refusal, three for being under 18 years old and nine because they were not in good physical condition at the time of the research.

For data collection, the woman's clinical record was used as a semi-structured instrument, which is considered standard by the 16th Health Region and distributed to the municipalities. This instrument was divided into five categories, the first for characterizing sociodemographic data; the second with description of vital signs, weight and the third related to lifestyle and risk behaviors; the fourth highlighting the presence of chronic non-communicable diseases and continuous use of medications, and the fifth category for collection regarding gynecological and obstetric history. Data from the second category, such as vital signs, weight and height, were collected by the researchers and transcribed into the instrument; the other data were collected through interviews with self-reported responses.

The data collection was conducted by the main researcher, a master's in nursing and a college professor, two academics from the last period from a private nursing school who had no connections to health services. These were previously trained and qualified for data collection, by the main researcher, through the presentation of the project, study objective, discussion of ethical precepts and application of the data collection instrument among them to identify any doubts regarding the questions and clarify them.

Data collection took place simultaneously by researchers in the municipalities included in the sample, and according to the flow of women and service hours at health institutions. Participants were recruited for the research as they attended institutions in the selected municipalities for medical consultations, collect preventive exams, prenatal and other exams, from Monday to Friday in the morning and afternoon periods. While the women waited for consultations, the researchers welcomed them and invited them to participate in the research and the data was collected in available rooms or offices ensuring their privacy.

Peer verification was performed to identify inconsistencies in information in the clinical records, and nine records were excluded, as they were incomplete, already considering the losses made by the sample calculation. For statistical analysis, all responses were tabulated in a database created in the Microsoft Excel software, by double entry and, subsequently,

analyzed using the R software (R Development Core Team, 2016), version 3.6.2.

A descriptive analysis of the results was performed to obtain data using absolute frequency and percentage for categorical variables. Association tests were conducted between sociodemographic characteristics, physical activity, risk behaviors (smoking, alcohol and drugs), surgery and continuous use of medications with chronic non-communicable diseases. The analysis of association between variables was evaluated using the Chi-square test at a 5% significance level.

To investigate possible associations between the variables of interest, univariate logistic regression was used, estimating Odds Ratios as a measure of effect, with a 95% confidence interval. Subsequently, using the methodology proposed by HOSMER and LEMESHOW, the variables that showed at least a moderate association ($p < 0.25$) with the variable of interest were selected using the Chi-square test. These variables were included in the multivariate model, which estimates the adjusted odds ratio, considering possible interactions between variables.

It is important to highlight that most of data collection (94% of the total set) was conducted between July 2019 and February 2020, that is, before the outbreak of the Covid-19 pandemic. With the beginning of the pandemic period, data collection was interrupted according to the safety guidelines established by the Ministry of Health and local public authorities, as a preventive measure. After a period of six months, data collection was authorized to resume in the large municipality, where part of the sample was still pending. This resumption, carried out in August and September 2020, followed all recommendations and safety standards for Covid-19 prevention. Despite the delay in completing the total sample due to the decrease in the number of visits to health institutions, it was possible to complete data collection without compromising the study methodology.

To access women of reproductive age in PHC health institutions, formal authorization was obtained from the health departments of the study municipalities, through the acceptance form signed by the health secretaries. The study was approved by the Permanent Ethics Committee on Research with Human Beings of the *Universidade Estadual do Paraná* – Unespar, Paranavaí campus), opinion no. 3,448,698 and complies with all the standards of resolution no. 466/2012 of the National Health Council of Brazil. The request to participate in the study was accompanied by two copies of the Informed Consent Form (ICF); The participants were notified about the research purposes, type of desired participation and the interview methodology, with one copy remaining with the interviewee and one copy with the researcher.

■ RESULTS

Among the 397 women of reproductive age interviewed, 153 (38.53%) reported a diagnosis of NCDs, the most frequent being obesity, hypothyroidism, depression and high blood pressure.

It was observed in Table 1 that the frequency of women over 31 years old, and who reported being a homemaker as a profession, is higher among those who reported NCDs

and both variables showed a statistical association with the presence of chronic disease ($p=0.001$).

Similarly, the association of religion, education, marital status ($p=0.001$) and color/race ($p=0.002$) were also significant regarding NCDs.

As shown in Table 2, there was a statistically significant association between BMI and the presence of NCDs ($p=0.001$), with the highest frequency identified among obese women, when compared to those who do not have a chronic disease.

Table 1 – Distribution of the population of women of reproductive age and sociodemographic characteristics in relation to NCDs in six municipalities in the 16th HR in northern of Paraná. Paraná, Brazil, 2020

Variables	Frequency		Without NCDs		With NCDs		p-value*
	n	%	n	%	n	%	
City							0.003
Municipality 1	275	69.26	186	76.23	89	58.17	
Municipality 2	37	9.32	22	9.01	15	9.80	
Municipality 3	26	6.55	12	4.92	14	9.15	
Municipality 4	24	6.05	11	4.51	13	8.50	
Municipality 5	24	6.05	11	4.51	13	8.50	
Municipality 6	11	2.77	2	0.82	9	5.88	
TOTAL	397	100	244	100	153	100	
Age group							0.001
18 to 20 years old	41	10.32	35	14.34	6	3.93	
21 to 30 years old	179	45.09	136	55.74	43	28.10	
31 to 40 years old	131	33.00	63	25.82	68	44.44	
41 to 49 years old	46	11.59	10	4.10	36	23.53	
Profession							0.001
Homemaker	118	29.72	47	19.26	71	46.41	
Student	40	10.08	40	16.39	-	-	
Seamstress	39	9.82	28	11.48	11	7.19	
Trainee	21	5.29	17	6.97	4	2.61	
Maid/Housekeeper	20	5.04	6	2.46	14	9.15	
Teacher	16	4.03	12	4.92	4	2.61	
Autonomous	16	4.03	10	4.10	6	3.92	

Table 1 – Cont..

Variables	Frequency		Without NCDs		With NCDs		p-value*
	n	%	n	%	n	%	
Administrative assistant	11	2.77	10	4.10	1	0.65	
Others	116	29.22	74	30.32	42	27.45	
Religion							0.001
Catholic	273	68.77	170	69.67	103	67.32	
Evangelical	81	20.40	48	19.67	33	21.57	
Spiritist	11	2.77	-	-	11	7.19	
Atheist	5	1.26	3	1.23	2	1.31	
Others	27	6.80	23	9.43	4	2.61	
Education level							0.001
None	1	0.25	-	-	1	0.65	
Incomplete primary education	32	8.06	19	7.79	13	8.50	
Complete primary education	38	9.57	20	8.20	18	11.76	
Incomplete high school	106	26.70	46	18.85	60	39.22	
Complete high school	116	29.22	74	30.32	42	27.45	
Incomplete higher education	68	17.13	62	25.41	6	3.92	
Complete higher education	36	9.07	23	9.43	13	8.50	
Marital status							0.001
Married	140	35.26	61	25.0	79	51.63	
Single	120	30.23	92	37.70	28	18.30	
Single (with stable union)	106	26.70	75	30.74	31	20.26	
Divorced	28	7.05	16	6.56	12	7.85	
Others	3	0.76	-	-	3	1.96	
Color/race							0.002
White	239	60.20	155	63.52	84	54.90	
Black	50	12.59	21	8.61	29	18.96	
Brown	105	26.45	68	27.87	37	24.18	
Indigenous	3	0.76	-	-	3	1.96	

Source: Research data, 2020.

Notes: * p-value < 0.05; - numerical data equal to zero, not resulting from rounding

A higher frequency of smokers and alcohol drinkers was observed among those who reported NCDs, compared to those without, with the association of these variables being significant ($p \leq 0.001$), as well as the occurrence of surgeries and use of medications ($p=0.001$).

Table 3 presents the results of the association between age group and the presence of NCDs. Women aged between 31 and 49 years old were almost four times more likely to have a chronic disease and those between 41 and 49 old were almost ten times more likely.

Table 2 – Distribution of Body Mass Index (BMI) frequencies, risk behaviors, surgery and continuous use of medications in relation to NCDs in six municipalities in the 16th HR in the northern state of Paraná. Paraná, Brazil, 2020

Variable	Absolute frequency		Without NCD		With NCD		p-value*
	n	%	n	%	n	%	
BMI							0.001
Underweight	2	0.50	1	0.41	1	0.65	
Normal weight	155	39.04	115	47.13	40	26.14	
Overweight	152	38.29	94	38.52	58	37.91	
Obesity	88	22.17	34	13.94	54	35.30	
Practice physical activity							0.107
No	306	77.08	181	74.18	125	81.70	
Yes	91	22.92	63	25.82	28	18.30	
Smoking							0.001
No	324	81.61	214	87.70	110	71.90	
Yes	73	18.39	30	12.30	43	28.10	
Alcoholism							0.001
No	376	94.71	239	97.95	137	89.54	
Yes	21	5.29	5	2.05	16	10.46	
Drugs							1.000
No	392	98.74	241	98.77	151	98.69	
Yes	5	1.26	3	1.23	2	1.31	
Surgeries							0.001
No	268	67.51	187	76.64	81	52.94	
Yes	129	32.49	57	23.36	72	47.06	
Medications							0.001
No	238	59.95	208	85.25	30	19.61	
Yes	159	40.05	36	14.75	123	80.39	

Source: Research data, 2020.

Note: * p-value=0.05.

Table 3 – Distribution of the population and factors associated with chronic diseases in women of reproductive age measured using Logistic Regression, multiple analysis and odds ratio estimation for six municipalities in the 16th HR in northern state of Paraná. Paraná, Brazil, 2020

Variable	Chronic diseases		Crude OR*	CI † (95%)	p-value‡,	Adjusted OR§,	CI** (95%)	p-value ††
	No n (%)	Yes n (%)						
Age group								
18 to 20 years old	35 (14.34)	6 (3.92)	1	-	-		-	-
21 to 30 years old	136 (55.74)	43 (28.10)	1.84	0.77-5.13	0.198	1.33	0.52 – 3.91	0.575
31 to 40 years old	63 (25.82)	68 (44.44)	6.3	2.64-17.54	0.001	3.67	1.41 – 10.85	0.011
41 to 49 years old	10 (4.10)	36 (23.54)	21	7.34-69.52	0.001	9.7	3.06 – 34.73	0.001
Education level								
None	- -	1 (0.65)	-	-	-	1	-	-
Incomplete primary education	19 (7.79)	13 (8.50)	1	-	-	1	-	-
Complete primary education	20 (8.20)	18 (11.76)	1.32	0.51-3.44	0.572	1.32	0.45 – 4	0.615
Incomplete high school	46 (18.85)	61 (39.23)	1.91	0.86-4.33	0.115	2.7	1.08 – 7.03	0.036
Complete high school	74 (30.33)	42 (27.45)	0.83	0.37-1.88	0.647	1.55	0.61 – 4.07	0.362
Incomplete higher education	62 (25.41)	6 (3.92)	0.14	0.04-0.41	0.001	0.45	0.12 – 1.52	0.203
Complete higher education	23 (9.42)	13 (8.49)	0.83	0.31-2.21	0.702	2.05	0.65 – 6.61	0.22

Table 3 – Cont..

Variable	Chronic diseases		Crude OR*	CI † (95%)	p-value‡,	Adjusted OR§,	CI** (95%)	p-value ††
	No n (%)	Yes n (%)						
Obesity								
No	210 (86.05)	99 (64.71)	1	-	-	1	-	-
Yes	34 (13.95)	54 (35.29)	3.37	2.07-5.55	0.001	2.25	1.28 – 4.01	0.005
Practice physical activity								
No	181 (74.18)	125 (81.70)	1	-	-	1	-	-
Yes	63 (25.82)	28 (18.30)	0.64	0.39-1.05	0.084	0.68	0.38 – 1.19	0.181
Smoking								
No	214 (87.70)	110 (71.90)	1	-	-	1	-	-
Yes	30 (12.30)	43 (28.10)	3.47	2.2-6.14	0.001	2.23	1.19-4.29	0.001

Source: Research data, 2020.
Notes: ‡p-value< 0.05; *OR= Crude Odds Ratio; †CI= Confidence interval; §Adjusted Odds Ratio; †† p-value, – CI and p-value could not be estimated

It is important to highlight that women with incomplete higher education have 14% of chances of developing chronic diseases compared to those with incomplete primary education (crude OR=0.14; $p=0.001$). This disparity persists even when we consider incomplete high school, as the chances were significantly higher for women with this characteristic compared to their respective baseline comparison.

Moreover, obese women ($p=0.005$) and smokers ($p=0.001$) were twice as likely to have NCDs (Table 3).

■ DISCUSSION

In the present study, age group, education level, obesity and smoking were factors associated with NCDs in women of reproductive age. Although women are the ones who most seek PHC services⁽¹⁰⁾, there is still a predominantly curative approach, focusing on clinical complaints and reproductive health⁽¹¹⁾.

Regarding age group, in the present study, a statistical association with the occurrence of NCDs was identified, a result that corroborates the findings of a study conducted in India with women of reproductive age, which showed a higher prevalence of NCDs in women aged between 40 to 44 years old (27.38%) and 45 to 49 years old (31.18%)⁽¹²⁾. Although it is a non-modifiable factor, the age group must be considered when planning screening actions, promoting self-care and encouraging changes in lifestyle habits⁽¹³⁾. Considering that most women in this age group are economically active, actions need to be developed in collective spaces at alternate times and days (including weekends and holidays).

The education level is another factor that must be considered in health education actions and encouraging self-care. This is because a lower education level directly influences health care performance⁽¹⁴⁾. Therefore, actions must be adapted according to the specificities of the public to achieve effective results.

Smoking is considered an important risk factor for the development of many chronic diseases, such as cancer, lung and cardiovascular diseases, so that the tobacco habit remains the global leader among the consequences of preventable deaths. According Vigitel 2021 data, the overall percentage of smokers aged 18 or over in Brazil is 9.1%, with 11.8% among men and 6.7% among women⁽¹⁵⁾. In the present study, the prevalence was 18.39%, an approximate value for the prevalence identified in a study conducted with 415 women in the state of Paraná (14.77%)⁽¹⁶⁾.

In Brazil, state health departments coordinate the Tobacco Control Program with treatment for users who want to quit the habit. Actions are decentralized to the municipalities acting in an integrated way in PHC through the FHS⁽¹⁷⁾. However,

some services are struggle to provide comprehensive treatment, as it includes clinical assessment, minimal or intensive, individual or group approach and, if necessary, drug therapy together with the intensive approach, and there is still a lack of trained professionals for patient reception, treatment monitoring, and continuous assessment aimed at relapses⁽¹⁷⁾.

Regarding the BMI of participants in the present study, more than 60% were overweight or obese to some degree. A study conducted in India showed an increase in the prevalence of overweight and obesity in the period 2005-2021, especially in women, with lower educational levels and with diabetes, and highlighted the need for specific strategies and policies based on the determinants to address overweight/obesity⁽⁴⁾. Likewise, an epidemiological study conducted with 2,018 women of reproductive age, in the city of Juiz de Fora, Minas Gerais, found that 61% of women were overweight or obese⁽¹³⁾.

Overweight and obesity have important impacts on women's health. According to the World Health Organization, obesity is considered a chronic disease and a risk factor for other diseases⁽²⁾. Obese women of reproductive age are at greater risk of gestational diabetes, miscarriage, hypertension, venous thromboembolism, cesarean section, postpartum bleeding and infections⁽¹³⁾. Additionally, the climacteric is a phase of the life cycle accompanied by metabolic problems that, when associated with obesity, increase mortality risk factors⁽¹⁸⁾. Therefore, it is urgent for healthcare professionals to routinely monitor and assess BMI in women's health care.

Even with lower prevalence, 20.15% of the participants in this study reported having been diagnosed with other chronic diseases such as high blood pressure, dyslipidemia, heart disease, cancer and others. Furthermore, 40.5% of these women reported continuous use of medications for disease treatment, among which are associated with women who reported a diagnosis of NCDs. These results corroborate the findings of a study conducted in an oncology hospital in Minas Gerais with 210 young women diagnosed with breast cancer, which found that 60.0% (126) of women had a pre-existing chronic disease⁽¹⁹⁾.

Another cross-sectional study involving 5,323 women, conducted at the General Hospital of Tianjin Medical University in China, identified that women at the end of reproductive age have high chances of cardiovascular diseases, diabetes mellitus, hypercholerastemia and high blood pressure, in addition to the risks of being overweight and obese⁽²⁰⁾. Analyzing the prevalence of chronic diseases and drug treatment among women of reproductive age in this study, it is important to consider that they are young women and capable of disease prevention and health promotion through the services offered by PHC.

This study also found a prevalence of 77.08% of a sedentary lifestyle in the total population of women of reproductive age, and the prevalence was even higher (81.8%) among those who reported a diagnosis of chronic disease.

A sedentary lifestyle is associated with negative outcomes in the healthy population as well as in individuals with NCDs. Practicing physical activity contributes to the prevention of chronic diseases, reduction of risk factors, prevention of complications from already established diseases, and also contributes to physical and psychological well-being⁽²¹⁾.

Considering the demand for care, the comprehensiveness of health care for women of reproductive age and through the expansion of PHC services, there are still many challenges related to cope with the changes arising in the social, demographic and morbidity and mortality profile of this population⁽²⁾.

It is important to highlight that public policies for comprehensive women's health care aim to provide care throughout all life cycles, however, in practice, comprehensive care is still not effectively considered, considering that the health system presents difficulties in assisting women in various specific areas such as disease prevention, menopause, infertility, mental health and occupational health^(4,6).

Thus, the importance of considering the performance of PHC as an axis for political-governmental proposals to change the health care model in the context of the Unified Health System (*Sistema Único de Saúde*) in Brazil is discussed, considering the profile of different populations such as women of reproductive age.

It is believed that the fact that the data is self-reported and come from six municipalities in a health region located in the northern Paraná, may constitute a limitation of the study. However, the results found offer support for planning NCDs screening actions in women of childbearing age, which can be developed through the assessment of risk factors in strategic locations and with the support and dissemination of social media and representatives of the community. Furthermore, any contact by health team members with women of reproductive age, especially those at higher risk, should constitute an opportunity for health education and awareness regarding the need for periodic monitoring of their health condition, self-assessment of behaviors, lifestyle habits, and the adoption of self-care actions.

■ CONCLUSION

The prevalence of chronic diseases among women of reproductive age was 38.53% and the associated factors were the age range of 31 to 40 years old, education level, obesity and smoking.

The results reinforce the need for interventions aimed at changing lifestyle and lifestyle habits still during childhood and adolescence, with a focus on self-care, to reduce risk behaviors in adulthood.

It is evident the need for integrated approaches in PHC to face challenges related to changes in the morbidity and mortality profile of this population, especially amidst increasing exposure to risk factors. Despite the existence of public policies aimed at comprehensive women's health care, the results provide support to rethink the strategies used, especially regarding the need for intersectoral involvement with a focus on health promotion and NCD prevention.

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