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LIFESTYLE PROFILE ACCORDING TO DEMOGRAPHIC, SOCIOECONOMIC AND SELF-PERCEPTION VARIABLES IN WOMEN, 2024

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ABSTRACT

Introduction: Studies show that, despite the growing awareness of the importance of healthy habits, women still face substantial barriers in trying to integrate these practices into their daily lives. These barriers can include lack of time, limited financial resources, mental and emotional health issues, and the influence of social norms that often do not favor health self-management. Objective: To describe women's perception of a healthy lifestyle. Materials and Methods: This is an analytical cross-sectional study conducted with 190 Brazilian women (33.66 ± 10.7 years), using a self-administered online questionnaire, collected between July and December 2024 and disseminated on social networks. Results: Most participants were without a partner (54.2%), childless (52.1%) and non-white (54.7%). Regarding lifestyle, 58.4% of the women were classified as having a risk profile and 41.6% as having a healthy profile. Although there was no statistically significant association between lifestyle and sociodemographic variables, the healthy profile was more prevalent among women without a partner, with less schooling, lower income, and up to two children. Conclusion: The findings suggest a possible misperception of healthy habits, evidencing the need for educational interventions. Female autonomy, education level, and number of children can influence lifestyle, but no statistical association was confirmed in this study, but reinforcing the importance of public policies and actions that promote healthy habits and reduce socioeconomic barriers.

Keywords: Women. Lifestyle. Self-assessment.

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INTRODUCTION

The adoption of healthy habits is essential for health promotion and prevention of chronic diseases, but it faces significant challenges in the context of contemporary lifestyle. The overload of responsibilities, long working hours, family demands and social pressure make it difficult to dedicate yourself to self-care, such as physical exercise and a balanced diet. This accelerated routine, marked by stress and lack of rest, represents a considerable obstacle to the construction and maintenance of these habits (Lima, 2022; Porto, 2006).

Studies show that, despite the growing awareness of the importance of healthy habits, women still face substantial barriers in trying to integrate these practices into their daily lives. These barriers can include lack of time, limited financial resources, mental and emotional health issues, and the influence of social norms that often do not favor health self-management (Santos, 2021).

According to Santos (2020), 46% of the world's population lives in poverty and among women in solitary motherhood, 29% are in the poorest quintile of the population. This group of women faces financial, social and emotional vulnerabilities and faces situations of inequality, humiliation and social abandonment. They are more likely to be in a situation of food and nutrition insecurity (FNI) and to present emotional disorders such as depression and anxiety, impacting health due to the deleterious lifestyle.

In this context, this article aims to examine the main barriers faced by adult women when trying to adopt healthy habits, in addition to exploring possible strategies to overcome these challenges. Aspects such as self-care, task overload and social support will be addressed, with the aim of contributing to the promotion of a healthier and more balanced life for these women. Thus, the objective of this study was to describe women's perception of a healthy lifestyle.

MATERIALS AND METHODS

This is an analytical cross-sectional study conducted with adult women aged 18 to 59 years, living in Brazilian territory. This is a convenience sample, covering participants from different states of Brazil, and all women who fit the specified age group and residing in the national territory at the time of collection are eligible.

During data collection, participation was encouraged through the dissemination of the survey on social networks, such as *Instagram* and *WhatsApp*, using posts and shares with the *link* to the *online* questionnaire, which was made available on *the Google Forms*

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platform. The answers were automatically organized in a spreadsheet in *Google Drive* for later analysis. Data collection took place from July to December 2024 through the self-administered questionnaire online, with the support of the researcher in case of doubts.

The data collection questionnaire included demographic, socioeconomic and lifestyle variables, in addition to the FANTÁSTICO that was used to classify the lifestyle of the participants. The FANTÁSTICO questionnaire, developed at McMaster University, Canada, and validated for Portuguese by Rodriguez-Anes *et al.* (2008) is an instrument with 25 questions that assess nine lifestyle domains in the last month: family and friends, physical activity, nutrition, smoking and drugs, alcohol, sleep and safety, behavior, introspection, and career.

Responses are scored on a scale of 0–4, resulting in a rating from "needs improvement" (0–34 points) to "excellent" (85–100 points). In this study, for inferential analysis, the original classification for lifestyle was grouped into Needs to improve/Regular/Good, and those who scored below 70 points on the instrument were characterized as "Risk Profile" groups; while the Very Good and Excellent categories, with a score equal to or greater than 70 points, were called "Healthy Profile" (Atz and Remor, 2022).

The data were analyzed using descriptive statistics, through absolute and relative frequencies, as well as inferential statistics, using Pearson's Chi-square test (x^2). For all analyses, the level of statistical significance was set at 0.05.

This study presented minimal risk to the participants and was approved by the Research Ethics Committee of the Centro Universitário Várzea Grande (CAAE80101824.3.0000.5692). All participants were guaranteed anonymity, privacy and confidentiality of the answers and their participation was formalized through the virtual Informed Consent Form with information about the study.

RESULTS

During the data collection period, 199 women answered the questionnaire, but 9 were excluded because they did not meet the inclusion criteria, 3 under 18 years of age and 6 of whom were 60 years of age or older, totaling a final sample of 190 women, with a mean age of 33.66 years (±10.7 years).

Regarding the demographic and socioeconomic profile of the sample (Table 1), women were predominant without a partner (54.2%), without children (52.1%), non-white

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race/color (54.7%), with more than 12 years of schooling (81.6%) and with an income of more than 3 minimum wages (75.3%).

Table 1. Absolute and relative distribution for sociodemographic characteristics.

Variables	n (190)	%
Marital status		
With partner	87	45,8
No companion	103	54,2
Race / color		
White	86	45,3
Not White	104	54,7
Schooling		
Up to 12 years	35	18,4
More than 12 years	155	81,6
Household income*		
Up to 3 minimum wages	41	21,6
More than 3 minimum wages	143	75,3
No. of children		
Childless	99	52,1
1 to 2 children	77	40,5
3 or more children	14	7,4

Source: The Authors, 2024. *Missing data from 6 participants.

The lifestyle addressed in this study through the FANTÁSTICO questionnaire resulted from the original classification of the scale that 51.6% (n=98) were concentrated in the Good category; 38.4% as Very Good; 6.8% as Regular and 3.2% as Excellent, as shown in Table 2.

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Table 2. Score of the FANTASTIC Lifestyle questionnaire.

Classification	Absolute frequency	Relative frequency
Needs to improve	0	0,0
Regular	13	6,8
Good	98	51,6
Very good	73	38,4
Excellent	3	3,2

Source: The Authors, 2024.

For inferential analysis, the original classification for lifestyle was grouped into Needs improvement/Regular/Good, 58.4%, and a "Risk Profile" group was defined as those who scored below 70 points on the instrument; while the categories Very Good and Excellent, 41.6%, with a score equal to or greater than 70 points, were grouped in the so-called "Healthy Profile", as shown in Table 2.

The two lifestyle profiles were compared in terms of sociodemographic variables, as shown in Table 3, but no variable showed a significant association. Even so, it was observed that the healthy profile was more prevalent in women without a partner (43.7%), non-white race/color (43.3%), who studied up to 12 years (43.9%), with an income of up to 3 minimum wages (43.9%) and who had between 1 and 2 children (42.9%), the latter reducing the prevalence as the number of children increased (35.7%).

Table 3. Absolute and relative distribution of the lifestyle profile, according to sociodemographic characteristics.

Variables	Risk profile		Healthy profile		p value
	n	%	n	%	
Marital status					
With partner	53	60,9	34	39,1	0,521
No companion	58	56,3	45	43,7	
Race / color					
White	52	60,5	34	39,5	0,603
Not White	59	56,7	45	43,3	
Schooling					
Up to 12 years	23	56,1	18	43,9	0,824

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More than 12 years	83	58,0	60	42,0	
Household income*					
Up to 3 minimum wages	23	56,1	18	43,9	0,824
More than 3 minimum wages	83	58,0	60	42,0	
No. of children					
Childless	58	58,6	41	41,4	0,882
1 to 2 children	44	57,1	33	42,9	
3 or more children	9	64,3	5	35,7	

Source: The Authors, 2024. *Missing data from 6 participants.

Most of the women interviewed consider themselves to have a healthy lifestyle (n=115), however, 60.5% (n=111) were classified as having a risk profile, according to the classification of the FANTÁSTICO questionnaire. On the other hand, 76.0% of the women who did not consider themselves to have a healthy lifestyle were classified as having a poor lifestyle, and even among those who considered them healthy, 47.0% of them also obtained this classification, with a significant difference between them, as shown in Table 4.

Table 4. Absolute and relative distribution of the lifestyle profile, according to self-assessment.

Variables	**n**	**%**	**Risk profile**		**Healthy profile**		**p value**
			n	**%**	**n**	**%**	
Do you consider your lifestyle healthy?							
Yes	115	60,5	54	47,0	61	53,0	0,000
No	75	39,5	57	76,0	18	24,0	
Total	190	100,0	111	58,4	79	41,6	

DISCUSSION

The present study analyzed the healthy lifestyle profile of women, based on the FANTÁSTICO questionnaire score, most of which were classified as risk profiles. No associations were observed with demographic and socioeconomic variables, only with self-assessment of lifestyle.

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Although no statistically significant association was identified between marital status and lifestyle, it is possible to consider that female autonomy plays a relevant role in health and self-care. Unacceptably large populations of women and girls in some type of union continue to lack access to the fundamental right to make decisions about whether or not to seek health care (UNFPA, 2023), showing that the context of greater freedom to decide about their lifestyle can positively impact the health of these women. Situations of greater autonomy can favor more conscious choices that are aligned with general well-being, avoiding the influence of shared behavior patterns that can compromise quality of life.

From a socioeconomic point of view, the prevalence of a healthy lifestyle was slightly higher among women with up to 12 years of schooling compared to those with more schooling, although the difference was not significant. This data contrasts with the literature, which generally associates higher education with better health indicators, according to Oliveira *et al.* (2022), there is a trend towards better QoL (quality of life) in the domains of independence, social relationships, and environment among individuals with a higher level of education, which reflects on lifestyle and reinforces the importance of education as a determinant of the population's health.

Possibly, women with less schooling may adopt more frequent home eating practices, such as preparing less processed meals, or be more exposed to public policies to encourage health, such as the distribution of basic food baskets or social programs such as Bolsa Família (BF). BF, for example, can have a positive impact on the food quality of beneficiary families, as it encourages the consumption of *natural* or minimally processed foods. A study carried out in the Northeast region found that BF beneficiaries had lower consumption of processed and ultra-processed foods in both regions analyzed and higher consumption of *natural* or minimally processed foods in the region (Sperandio *et al.*, 2017).

A study conducted by Bortoletto (2013) showed that access to the BF program in low-income households translated into higher per capita spending on food, greater availability of *fresh* or minimally processed foods and culinary ingredients, indicating greater access to food. These data reinforce how economic power affects lifestyle, when particularized in food choices.

On the other hand, more educated women may face barriers such as long working hours and greater dependence on ready-to-eat or ultra-processed foods, due to lack of time. This can be explained by changes in the lifestyle of families, driven by women's participation in the labor market, urbanization and technology, in addition to the investment

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of the food industry in the development of ultra-processed products to make them hyperpalatable, ready for consumption, durable, practical and accessible to all social strata of the population (Pereira *et al.,* 2021). The absence of a significant association suggests the need for further investigations on the relationship between schooling and lifestyle.

No association between income and lifestyle was observed, however, as already mentioned, we cannot rule out the influence of economic role on lifestyle, since people of higher economic level have more access to healthy practices and leisure options (Souza, 2019), even impacting their satisfaction with health and quality of life (Sousa *et al.,* 2021). A study conducted with 113 women aged 20 to 65 years, in a health unit in São Paulo, showed, for example, that income, as a fundamental component in the definition of an individual's social status, showed a strong association both with the general perception of quality of life (QoL) and with the aspect of social relationships (Cazella *et al.,* 2019).

Although the study shows that those who are mothers with 1 to 2 children had a prevalence of a healthy profile, being higher than among those with 3 or more children, no significant association was found between the number of children and lifestyle. This reduction may be related to the greater burden of responsibilities in larger families, which can compromise the time available for self-care, physical activity, and food planning. In addition, the increase in the number of children can lead to the prioritization of quick and practical meals, often associated with lower nutritional quality, such as the consumption of ultra-processed foods.

It should be noted that ultra-processed products were attractive to the population, due to their practicality, since they do not require almost any culinary preparation, and their use is intensified with the greater participation of women in the labor market and the contemporary lifestyle, characterized by the lack of time to prepare meals (Silva, *et al.* 2019).

Finally, the data reveal a marked discrepancy between the self-assessment of lifestyle and the objective classification obtained by the FANTÁSTICO questionnaire. While 60.5% of the women considered their lifestyle to be healthy, 47.0% of them were classified as having a risk profile. This difference may reflect a misperception about what constitutes a healthy lifestyle. Many participants may associate health only with the absence of disease or with isolated practices, such as avoiding certain foods or doing sporadic exercise, without considering the overall context. This reinforces the importance of

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educational interventions to clarify the concept of a healthy lifestyle and promote a more comprehensive and realistic view (Palmeira *et al.,* 2021).

On the other hand, the fact that 76.0% of women who did not consider themselves healthy were effectively classified as having a risky lifestyle indicates an initial recognition of inappropriate practices or warning signs in their health. However, this recognition does not seem to be accompanied by sufficient knowledge to reverse the situation, reinforcing the gap in health education.

Although no significant associations were found in this study with demographic and socioeconomic data, the data point to relevant trends for the analysis of social determinants of health, especially in this population, since the literature reinforces that factors such as marital status, education, income, and number of children significantly influence health habits. highlighting the importance of intersectoral approaches in promoting healthy lifestyles, especially in vulnerable populations.

Among the strengths of this study, the scope of the analysis stands out, which incorporated several sociodemographic factors and their relationship with a healthy lifestyle, using the FANTÁSTICO questionnaire as an objective evaluation tool. The investigation of the discrepancy between self-assessment and objective lifestyle classification deserves special attention, as it reveals significant distortions in the participants' perception of what constitutes healthy habits.

This analysis points to the need for more robust educational interventions, which help to build a more realistic and broad view of health and quality of life. In addition, the inclusion of sociodemographic variables such as marital status, education, income, and number of children allows for in-depth reflections on factors that impact women's health, such as autonomy, family responsibilities, and the challenges imposed by the labor market. The analysis also highlights the impact of socioeconomic conditions on the formation of daily habits, addressing issues such as the role of public policies, and urbanization. Another positive aspect is that the study enriches the academic debate on health and body image perception, opening new avenues for future discussions and research.

However, some limitations should be highlighted, including the small sample size, which may have compromised the statistical power necessary to identify significant associations between some variables and healthy lifestyle. Another limiting factor is that the sample was composed mostly of women with higher purchasing power, restricting the generalization of the results to more diverse socioeconomic contexts, particularly to

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populations in greater vulnerability. This fragility reinforces the importance of interventions that broaden the understanding of the concept of health.

These limitations highlight the need for future larger studies, with greater population representativeness, which allow for a more detailed investigation of the relationships identified in the findings presented in this study.

CONCLUSION

The present study sought to understand the challenges that adult women face when trying to adopt a healthy lifestyle, exploring how social and personal factors shape this journey. Although many participants classified themselves as healthy, the results of the FANTÁSTICO questionnaire showed that more than half of them were classified as a risk profile, revealing a mismatch between self-assessment and the reality of the habits adopted.

Although no statistically significant associations were found between lifestyle and demographic or socioeconomic factors, some trends drew attention, suggesting that autonomy, social status and challenges in time management may play an important role in health-related choices, making it difficult to implement healthy practices in daily life.

In view of these findings, it is essential to deepen the investigation of the difficulties faced by these adult women to adopt healthy habits consistently. In addition, it is essential that public policies and intervention strategies are developed to support them in this process, creating an environment that facilitates balanced food choices, encourages the practice of physical activity, and promotes general well-being.

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