Annals of Agricultural and Environmental Medicine 2015, Vol 22, No 3, 546–550
www.aaem.pl

ORIGINAL ARTICLE

Level of information about gynaecological prevention in teenagers at risk from social exclusion, referred by family court rulings to juvenile attendance centres – a pilot study

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Bobiński M, Piątkowski W, Sadowska A, Dorota C, Bednarek W. Level of information about gynaecological prevention in teenagers at risk from social exclusion, referred by family court rulings to juvenile attendance centres – a pilot study. Ann Agric Environ Med. 2015; 22(3): 546–550. doi: 10.5604/12321966.1167732

Abstract

Introduction and objective. The objective of the study was to present preliminary results of a pilot study concerning the level of knowledge of gynaecological prevention, conducted in teenagers referred by court rulings to a juvenile attendance centre.

Materials and method. The instrument was an anonymous survey questionnaire completed by participants in health prevention classes in late 2010 and early 2011. The studied group consisted of teenagers aged 15–17 years (mean age: 15.72 years, median = 16 years, SD = 0.679) who were under probation officers' supervision in the Zamość region of south-eastern Poland. The sample size was 101 persons – 51 boys (50.50%), 50 girls (49.5%).

Results. According to the respondents, the most important reasons for seeing a gynaecologist were: menstrual disorders (70.30%), suspicion of pregnancy (63.37%) and pain or burning sensations while urinating (58.42%). The following were regarded as prevalent cancers in women: cancers of the breast (99.01%), cervix (89.1%), and ovaries (62.38%). Over 92% of subjects stated that it was possible to protect oneself from cervical cancer, but only 41.5% of respondents indicated the correct definition of the term 'cytology'. Statistical analysis focused on differences between genders. A higher self-assessment of mental health was shown in boys.

Conclusions. Teenagers of similar background may find it more difficult to gain access to knowledge about health prophylaxis, including gynaecological prevention. Efforts should be intensified in order to 'equalize health opportunities' through appropriate preparation of teaching curricula (including health education and philosophy of medicine).

Key words

gynecological prophylaxis, exclusion, teenagers, sociology of health

INTRODUCTION

For many years, the problems of social exclusion have attracted the attention of representatives of the social sciences (*inter alia* medical sociology and medical anthropology). Interdiciplinary academic research into the increased efficiency of health prevention/preventive care is an important element of the modern philosophy of medicine [1]. The great number of investigative approaches applied in descriptions and interpretations of the phenomenon in question has resulted in many definitions and diverse theoretical presentations. The following are usually listed, among others, as typical features of marginalization: multidimensional deprivation, measured by economic indicators and by others which are difficult to measure; participation and access deficits; restrictions on the realization of social benefits; and finally, the so-called 'hereditary nature' of the problem [2], which is particularly significant with reference to the social category of children and young people [3]. The exclusion of this group is the object of interest on the part of social policy scholars, which was manifested in a comprehensive analysis of the problem in *Joint Report on Social Protection and Social Inclusion* by the European Commission [4], and the proclaiming of 2010 to the year devoted to the prevention of poverty and marginalization in the European Union.

In the case of the category of children and teenagers, the object of analysis are different types of exclusion: *structural* (related to the residential environment, low educational level and bad economic conditions of the family), *physical* (determined by age, disease, disability), and *normative* caused by addictions, social discrimination, or by conflicts with the law) [5]. When presenting the characteristics of teenagers at risk from marginalization, who received institutional support (Voluntary Labour Corps, juvenile shelter, youth custody centre), Z. Gaś pointed to the structural and family determinants of this situation (disturbed structure/breakup, death of a close family member or friend, alcoholism, parental/siblings' delinquency, primary/basic vocational education of parents), the result of which may be the appearance of dysfunctional behaviour in children and teenagers (including coming into conflict with the law and substance abuse) [6]. J. Czapiński's typology [5] may also prove useful in describing the situation of teenagers at risk from social exclusion who were referred to juvenile attendance centres following rulings by family courts.

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Received: 06 August 2013; accepted: 13 May 2014

Referral to a juvenile attendance centre is an essential element of the juvenile rehabilitation system in Poland. Pursuant to the *Regulation of the Justice Minister Concerning Juvenile Attendance Centers,* a juvenile is admitted to an attendance centre following a court ruling. These centers conduct preventive, educational/guidance and rehabilitational/ therapeutic activities aimed at channeling the attitudes of the juveniles towards social acceptability, ensuring the correct development of their personalities. This is achieved, in particular, through: satisfaction of personality needs, solving mental problems, teaching the juveniles to cope with life difficulties on their own, elimination of educational and parental neglect, and compensating for background differences, as well as through teaching the attendees to observe social norms, developing their interests, inculcating in them right habits of spending free time, relieving emotional stresses, and through developing their sense of responsibility and protectiveness [7].

In order to accomplish the foregoing tasks, attendance centres organize classes with the participants and initiate cooperation with state and community institutions, with local self-government units, in particular with district family support centres, etc. Meetings with the parents or guardians of the attendees are also important: their aim is to analyze the course of the rehabilitation process and to define or modify educational methods. Classes with the attendees consist primarily in the organization of their free time, cooperation with the local environment, conducting therapy, and providing help in the elimination of educational and parental neglect. The *Law on the Procedure in Juvenile Cases* provides for the referral to an attendance centre as an educational measure for teenagers who commit punishable offences, i.e. theft, mugging, drug abuse, failure to fulfill schooling duty, and demoralization [8].

Statistical data provided by the Ministry of Justice show a comparatively stable tendency towards rulings for referral to juvenile attendance centres. Between 2009–2012, this happened in 782, 764, 835 and 735 cases, respectively [9]. The reported decrease, however, should not be attributed to the improved situation (a decrease in the number of persons against whom the court is obliged to issue a ruling) but to demographic conditions. Currently, there are 102 juvenile attendance centres in Poland, of which as many as 19 are in the Lublin province [9]. Figures given in the *Rocznik Statystyczny Województwa Lubelskiego* [Lublin Province Statistical Yearbook] show that in 2011 regional courts ruled in juvenile cases in connection with demoralization or punishable offenses – 1,828 and 36,96 cases, respectively, under explanatory proceedings, and, at a sitting or trial in 1,531 and 2,160 cases [10].

The marginalization of children and teenagers may occur from the aspect of limited participation in social life or as deprivation of goods and values regarded as useful or necessary to function in a community in a satisfying way. Analyses in the sociology of health, illness and medicine allow the conclusion that for many years health has been invariably recognized by the Poles as one of the supreme values [11], while 'equal access' to health can be realized only through the provision of 'equal opportunities'. According to A. Ostrowska:

"Long-term actions for decreasing health inequalities should cover all spheres of social life in which these social inequalities arise and persist. This applies both to decreasing the basic social inequalities observable in the structure of education, wealth and authority, in access to health care, prevention of social isolation and exclusion, i.e. in the development of social capital, and to well-planned actions in health education and health promotion that are geared towards forming pro-health living and working environments, and towards enhancing individual health competence" [12].

The present diagnosis may be the grounds for conducting information actions, prevention campaigns promoting health among 'neglected teenagers' who are thus faced with limited life choices, largely determined by financial and economic factors. The financial situation of the family in the context of health education was referred to *inter alia* by B. Woynarowska, who placed it, along with the parents' education and social exclusion, in the group of determinants of the satisfaction of a child's health needs. [13]. M. Zadworna-Cieślik and N. Ogińska-Bulik, in turn, analyzed the importance of parents' information support and preventive health behaviour as predictors of health behaviours of boys and girls aged 17–19 years [14].

OBJECTIVE

The aim of the study is to present preliminary results that are the outcome of a pilot study on the level of knowledge about gynaecological prevention, carried out in teenagers referred to a juvenile attendance centre by court rulings. In view of the local character of the project (Lublin province, districts: Biłgoraj, Hrubieszów, Janów, Krasnystaw, Tomaszów Lubelski, and Zamość) the authors are aware of the limitations of the generalizations made.

MATERIALS AND METHOD

The research instrument was an anonymous survey questionnaire completed by the participants in the classes in health prophylaxis conducted under the '*Szansa*' [Opportunity] project implemented by the Foundation for Development of the Lublin Region in collaboration with the Regional Court in Zamość. The survey was carried out in late 2010 and early 2011 (December 2010 – February 2011). The authors obtained the official consent of probation authorities to conduct research among the teenagers, and participation in the survey was voluntary.

The studied group consisted of teenagers aged 15–17 years (mean age – 15.72 years; median – 16 years; SD – 0.679) who were under the supervision of probationary officers in the jurisdiction area of the Regional Court in Zamość. The sample consisted of 101 respondents – 51 boys (50.50%) and 50 girls (49.5%).[1]

1. The problems of the influence of gender on the knowledge about health and prevention have been discussed by: Mareka E, Dergezb T, Rebek-Nagyc G, Szilardd I, Kissa I, Embera I, Goczee P, D'Cruz G.: The effect of educational intervention on Hungarian adolescents' awareness, beliefs and attitudes on the prevention of cervical cancer, in: Vaccine 2012:30: 6824– 6832. Hassan EA, Creatsas GC: Adolescent Sexuality – A Developmental Milestone or Risk-Taking Behaviour? The Role of Health Care in the Prevention of Sexually-Transmitted Diseases, in: J Pediatr Adolesc Gynecol 2000; 13:119–124. Rovei V, Gennarelli G, Lantieri T, Casano S, Revelli A, Massobrio M. Family planning, fertility awareness and knowledge about Italian legislation on assisted reproduction among Italian academic students, in: Reproductive BioMedicine Online 2010; 20: 873– 879.

Because of the characteristics of the studied sample, the authors chose a random survey, which was meant to minimize the respondents' feelings of shyness, shame, and embarrassment caused by the problems investigated [15]. In seeking to obtain the maximal reliability of answers, the authors also decided not to ask the respondents to name their places of residence. It was assumed that the respondents came from the same area under the jurisdiction of the Regional Court in Zamość; consequently, they functioned in the local communities of the districts listed above, whose inhabitants numbered 495.8 thousand (largest town: Zamość – 65.7 thousand) [16]. The sample characteristics were complemented by earlier information about the features of the persons referred to juvenile attendance centres: teenagers who had committed punishable offences and showed signs of demoralization. The context was the social and economic situation of the residential environment of the subjects, i.e. the Lublin province [17], regarded as one of poorer provinces in Poland and included among the poorest areas in the European Union. The authors are aware that the studied group cannot be recognized as uniform in terms of financial status because not all juveniles referred to juvenile attendance centres came from poor families.

The questionnaire contained questions concerning the level of respondents' knowledge about prevention of women's gynaecological diseases, self-assessment of health condition (both from the physical and mental aspects) and personal data (age and gender). In particular, questions were asked about the reasons that the respondents regarded as factors motivating them to visit a gynaecologist, the frequency of prevention consultations with a gyneacologist, frequency of incidence of particular cancers in women, and the possibilities of preventing cervical cancer.

101 survey questionnaires were qualified for statistical analysis; 5 questionnaires were rejected because of incomplete answers. The results were statistically analyzed using the IBM SPSS Statistics v.20 program. To analyze the statistical significance of differences between groups, the Bartlett (p) and variance analysis (f) tests were used. To analyze relationships between variables, the Pearson correlation coefficient r and the Chuprov convergence coefficient T were applied.

RESULTS

Among the significant reasons for visiting a gynaecologist, the respondents most often selected the following: menstrual disorders (70.30%), suspicion of pregnancy (63.37%) and painful or burning sensations while urinating (58.42%) (Fig. 1). These factors were most frequently chosen by the subjects of both genders. The factors least often indicated were, among others, 'vulvar itching' (13.86%) and 'after the first period' (15.84%). Statistically significant differences between genders were found regarding such reasons for visiting a gynaecologist as menstrual disorders (indicated as significant by 84.31% males and 56% females; p=0.032; f=0.0303) and 'after the first period' (respectively, 31.37% and 0%; p<0.005; f<0.005).

In the next part of the questionnaire, the respondents were asked to choose from the categories listed the three most frequent cancers in women. The prevalent answers were: breast cancers (99.01%), cervical cancers (89.1%), and

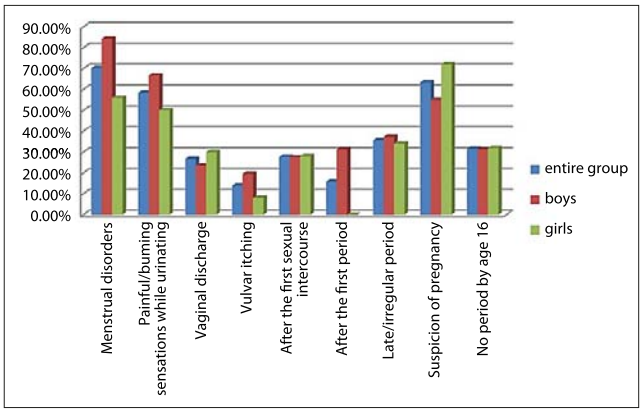

Figure 1. Factors justifying a visit to the gynecologist.
Source: Authors' study

ovarian cancers (62.38%). Colon cancers and lung cancers were indicated as most frequent by 7.92% and 22.77% of respondents, respectively. In this part of the survey, no statistically significant differences between the groups of boys and girls were found.

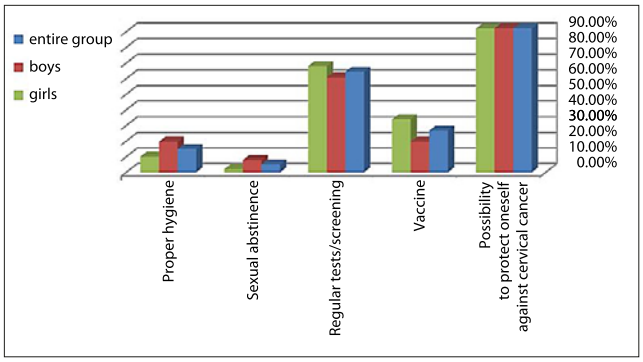

Figure 2. Assessment of the level of knowledge about cervical cancer prophylaxis.
Source: Authors' study

A part of the survey assessed knowledge about prophylaxis of cervical cancer. Over 92% (92.08%) of respondents answered in the affirmative to the question: 'Is it possible to protect oneself against cervical cancer?' No significant difference between the studied boy and girl groups were shown (Fig. 2). In this section of the survey, the respondents were also asked to choose the definition of the term 'cytology' from the choices given. The correct answer was indicated by only 41.58% of respondents (boys – 29.41%, girls – 54%). Using the statistical tests described in the methodological section, no significant differences between the groups were found (p=0.529; f=0.528).

The respondents were also asked to self-assess their physical and mental health condition on a scale of 1–5 (Tab. 1). No relationships between the mental and physical health condition of individual respondents were demonstrated.

Table 1. Self-assessment of mental and physical health condition

	Mental health condition	Physical health condition	Pearson correlation coefficient r	Chuprov convergence coefficient T
Boys	3.157	3.568	0.283	0.02
Girls	3.02	3.26	0.365	0.021

Source: Authors' study

With respect to physical health condition, no significant differences between the groups were shown (p=0.4845; f=0.481). However, a higher self-assessment of mental health condition was found in boys (p= 0.0301; f= 0.023022), which is confirmed in the literature on the subject.

DISCUSSION

To-date, assessment of the level of knowledge about gynaecological prevention has not been the subject of systematic analysis concerning teenagers [18, 19], whereas the relationships between sexuality and health have been described by A. Ostrowska and Z. Izdebski in the study *Seks po polsku. Zachowania seksualne jako element stylu życia Polaków* [Sex the Polish way. Sexual behaviors as an element of the Polish lifestyle]. From the sociological aspect, the study focused on the realization of such pro-health behaviours as, *inter alia*, having a gynaecological checkup at least once everysix months, breast self-examination, 'safe sex', understood as a change towards safer behaviours or refraining from risky sexual behaviours. According to A. Ostrowska, persons of younger age were more prone to practice both pro-health behaviours and more health-risky behaviours [20]. The attitude to health education and knowledge about HIV/AIDS were also analyzed in subjects aged 15–49 in the above-mentioned study.

The importance of gynaecological prevention cannot be overestimated during the period of economic, social and morals transformations which have resulted in the growing risk of sexually-transmitted diseases. This is an extremely relevant problem because of the increasingly low age of sexual initiation. In light of the results of representative all-Polish studies analyzed by B. Woynarowska and J. Mazur in 2002, almost 15% of teenagers aged 15 years had already had sexual initiation (in the Lublin province this coefficient was 13.9%) [21].

Health awareness is closely related to cancer prevention (cervical cancer, breast cancer, ovarian cancer) manifested in the use of screening tests offered under the National Health Fund (NFZ). Ignorance of basic problems and inability to self-assess the first disease symptoms may be a serious obstacle to receiving earlier medical consultation and thereby contribute to an individual's exclusion. Regrettably, incomplete data on health screening (prophylactic examinations) in Poland cannot be regarded as satisfactory [22].

Promising results in the area of health education were emphasized by M. Charzyńska-Gula, who analyzed the results of the implementation of the *Środowiskowy Program Wychowania Zdrowotnego w Szkole* [Community Program of Health Education in School] [23]. B. Dyczewski, in turn, sought ways of preventing social marginalization in social campaigns conducted by the media. Among the problems worth noting, the following were indicated, in the order of importance: health, HIV/AIDS, addictions, and juvenile delinquency [24], among others.

The foregoing remarks are consistent with the experience of one of the authors of the presented study, who, while conducting prevention classes among teenagers referred to a juvenile attendance centre, was able to observe the behaviours of participants, their response to the presented material, and vivid interest in health issues. It is not without significance that after the end of classes the participants were given the opportunity to present their opinions about the training (independently and unsupervised – without the teacher's presence) on a cardboard sheet provided. Their suggestions and remarks were usually positive.

CONCLUSIONS

The presented results obtained from a pilot study are limited, but they make it possible to emphasize several significant problems. Social exclusion is a relatively recent concept in the field of the social determinants of health, which finds its conceptual roots in a broadening of the concept of poverty [25]. There is invariably demand for reliable information on health prevention, including gynaecological prevention. The problem of the marginalization of increasingly broad categories of teenagers is still important: a particularly significant phenomenon in the aspect of access to information on health, prevention, and health promotion. Teenagers being brought up in an environment that requires the supervision of a probation officer may have more difficult access to this kind of information. Efforts should be intensified in order to 'equalize health opportunities' through the appropriate preparation of teaching curricula and rehabilitation programmes.

The phenomenon of social exclusion of teenagers referred to juvenile attendance centers deserves a systematic and in-depth analysis, taking into account the perspectives of sociology, health promotion and health education, and allowing for the specific characteristics of this risk group. Philosophy of medicine (in terms of doctor-patient interaction) should be adapted to patients' awareness of particular health problems and their social determinants. This leads to the conclusion that understanding teenagers' attitudes towards health prevention, especially the sex-related aspects, might be essential for appropriate adjustment of the behavior of doctors, based on experiences of both philosophy and sociology of medicine [19].

Acknowledgement
Level of information on gynaecological prevention in teenagers at risk from social exclusion, referred by family court rulings to juvenile attendance centres – a pilot study.[2]

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