CHARACTERISTICS OF THE DOMAINS OF QUALITY OF LIFE IN PREGNANT WOMEN OF THE FAMILY HEALTH STRATEGY

ABSTRACT
Objective: to characterize domains of quality of life of pregnant women, according to the survey of quality of life WHOQOL-bref. Method: descriptive, transversal study with quantitative approach. The population consisted of 120 pregnant women attended in the basic attention to health in the municipality of Sousa-PB/Brazil. Data collection occurred through a form relating to characteristics of pregnant women and the WHOQOL-bref instrument. The results were organized in an electronic database, coded, tabulated and presented in figures. The research project has been approved by the Research Ethics Committee, Protocol n° 633122010 Results: according to WHOQOL-bref of the quality of life, the dissatisfaction that predominated in the areas were: physical domain: pain, discomfort, sleep, rest, energy and fatigue. On the psychological: body image and appearance, memory, concentration and negative feelings. Social relations: sexual activity and in the environment more facets dissatisfaction were: financial resources, recreation and transportation opportunities. Conclusion: the quality of life of these pregnant women was considered unsatisfactory for these facets. 

Descritores: Nursing; Quality of Life; Pregnant Women; Prenatal.

RESUMO
Objetivo: caracterizar os domínios da qualidade de vida de mulheres grávidas, segundo o questionário de qualidade vida WHOQOL-bref. Método: estudo descritivo, transversal com abordagem quantitativa. A população constou de 120 gestantes atendidas na atenção básica de saúde no município de Sousa-PB/Brazil. A coleta de dados ocorreu através de um formulário referente às características das gestantes e o instrumento WHOQOL-bref. Os resultados foram organizados em um banco de dados eletrônico, codificados, tabulados e apresentados em figuras. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, Protocolo n° 633122010 Resultados: quanto à qualidade de vida, segundo o WHOQOL-bref, as insatisfações que predominaram nos domínios foram: domínio físico: dor, desconforto, sono, repouso, energia e fadiga. No psicológico: imagem corporal e aparência, memória, concentração e sentimentos negativos. Nas relações sociais: a atividade sexual e no meio ambiente as facetas com maior insatisfação foram: recursos financeiros, oportunidade de lazer e transporte. Conclusão: a qualidade de vida destas gestantes foi considerada insatisfatória para estas facetas.

Descritores: Enfermagem; Qualidade de Vida; Gestantes; Pré-Natal.

RESUMEN
Objetivo: caracterizar los dominios de la calidad de vida de mujeres embarazadas, según el cuestionario de calidad vida WHOQOL-bref. Método: estudio descriptivo, transversal con abordaje cuantitativa. La población constó con 120 gestantes atendidas en la atención básica de salud en el municipio de Sousa-PB/Brasil. La recolección de datos fue a través de un formulario referente a las características de las gestantes y el instrumento WHOQOL-bref. Los resultados fueron organizados en un banco de datos electrónico, codificados, tabulados y presentados en figuras. El proyecto de investigación fue aprobado por el Comité de Ética en Investigación, Protocolo n° 633122010 Resultados: sobre la calidad de vida, según el WHOQOL-bref, las insatisfacciones que predominaron en los dominios fueron: dominio físico: dolor, incomodidad, sueño, reposo, energía e fatiga. En lo psicológico: imagen corporal y apariencia, memoria, concentración y sentimientos negativos. En las relaciones sociales: la actividad sexual y en el medio ambiente las facetas con mayor insatisfacción fueron: recursos financieros, oportunidad de recreación y transporte. Conclusión: la calidad de vida de estas gestantes fue considerada insatisfactoria para estas facetas.

Descritores: Enfermería; Calidad de Vida; Gestantes; Pré-Natal.
INTRODUCTION

Pregnancy is not considered a disease, but it happens in the body of the woman inserted in the context of the family who sees motherhood as a social obligation. Socioeconomic factors and the subordinate condition of women interfere with the health-disease process and configure themselves as examples of illness and death. For the purpose of program standardization activities in prenatal control led to pregnant women, it is necessary to have tools to identify the context of life of these women and map the risks to which they are exposed, allowing direct and forward appropriately these in each stage of pregnancy.¹

The social demographic conditions and individual characteristics of pregnant women are risk factors that may interfere in the course of a healthy pregnancy, among other causes such as biological, current and previous obstetric and diseases must be tracked during prenatal consultations.¹²

It has been observed that there is a lack of studies based on the quality of life (QOL) in pregnant women in the international context and rare in Brazil, with real need in assessing the changes occurring during pregnancy because there is no data that show patterns of expected changes in health-related quality of life (HRQOL) of pregnant women or to deny its existence. Thus, there is a lack of normative data of low-risk pregnancies related to QOL to establish comparisons with groups of pregnant women at high risk.³

When using a general HRQOL instrument, it is trying to find and understand what is important to pregnant women, since this information shall be indicators of quality of care and that during pregnancy and puerperium does not have accurate information about QOL and psychosocial data. Certain searches cover the term pathological factors such as HIV, women affected by breast cancer, but little has the respect of QOL and its effects on normal pregnancy or related to psychological state.⁴

Study done on perception of well-being and functional status in low-risk pregnant women belonging to minorities multiethnic low-income and relationship with depression and social support concluded that there are high levels of depressive symptoms related to the low degree of perception of roles based on the health and well-being. Changes in functional status may affect the use of health services as adherence to treatment recommendations, consultations of mothers and their children. Similarly, increase in depressive symptoms and fall in different functional states were observed, suggesting that women of racial minorities from low-income families may experience higher stress levels than others during pregnancy.⁵

Cohort study with 125 pregnant women using measurable instruments of QOL with purpose to evaluate perceived changes in HRQOL and another to assess any pregnancy complications concluded that functional status during pregnancy has changed only in the physical dimension of health and social demographic factors have detected reduced health-related influence during pregnancy.⁶

With experience being a mother, but also by health care aimed at pregnant women, it realizes that, despite the gestation do not configure a disease, physiological changes, psychological and sexual that permeate the life of the woman in this period can change her QV. Based on these assumptions, emerged the need arose to develop this study among pregnant women seen in the basic attention taking into consideration its social context, leaving the chance to check the possible association between pregnancy and change in QOL of these women.

In this perspective, the results of this work can bring benefits to pregnant women, since the assessment of QOL and identification of social demographic factors in correlation with the lives of these may subsidize the elaboration of a protocol that will meet not only the needs of quality of care but also of QOL of these users. This has its social relevance as brings inherent discussions feminine universe, precisely in the gravid period with the purpose of promoting integral prenatal care.

Related to the management of health services, this work may display results that awaken the discussion of policies geared to the attention to the health of pregnant women seen in the basic network, in order to enable the planning of actions directed to this population. With regard to the health service, it can enhance the professional assistance that focus the QOL related issues, with allowances for changes in practice health care of pregnant women in the Family Health Strategy (FHS), allowing focus care attention centered only in the clinic to a general approach, surpassing the simplistic and limited vision of assistance. For science is relevant, since QOL related studies in pregnant women are scarce, especially in Brazil, although there is literature on QOL in pregnant women at the international level. Thus, this study comes contribute to add and
to characterize the domains of quality of life of pregnant women, in which the QOL should be the central axis, since its inception until the last days of life.

Studies on this subject are important, since from the knowledge of people in daily life QOL may emerge actions directed at interventions in risk and vulnerability of the diseases confronting the causes by technical and specific criteria to the culture and personality of the individual balance.7

As soon as there is knowledge of QOL of the population, change occurs in the paradigm of the attendance practice health-disease process surpassing the biomedical model, which, most of the time, does not appreciate the socioeconomic and cultural aspects important factors on the actions of promotion, prevention, treatment and rehabilitation in health.6

In this way, it can realize how much assistance focused on pregnant women need improve their quality in an integral and qualified way. When performing an integral attendance, it must include relevant aspects such as psychological, social, biological, sexual, cultural and environmental issues. This implies improving the quality of health services as well as promotes the QOL of pregnant women.

Under these considerations, this study aims to characterize the domains of quality of life of pregnant women, according to the survey of WHQOL-brief quality life.

METHOD

Article elaborated from the dissertation << Quality of life in pregnant women in the context of the Family Health Strategy >>, of the Post-graduate Program Master/Doctorate in Nursing/UFRN, defended in May 2011.

Descriptive transversal study with quantitative approach, characterized by research with systematic procedures for the description and explanation of the phenomena pursued by the scientific method which consists of delimit a problem, perform observations and interpret them based on relationships found, being based upon, if possible, on existing theories.9

The study was conducted in the municipality of Sousa/PB/Brazil, located in the northeastern region of Brazil, in the semi-arid region in the State of Paraíba, 450 km from the state capital. The health administrative region has 26 ESF units, of these, 19 are in the urban area and the remaining rural areas. In each unit there is a team of approximately 14 professionals who watch an area assigned from 800 to 3,120 individuals. The first team was deployed in 2002 and in all work: a nurse, a doctor, a dentist, a dental Office Assistant (DOA), a nursing technician, an attendant and six community health agents (CHA) varying according to the area, and may increase this quantity. In this context, the survey was conducted in all basic health units of the municipality. The municipality of Sousa occurred mainly because it was considered the place of residence and work as graduate student in managing team of the Municipal Health Secretariat of Sousa/PB. (MHS).

The population was constituted of pregnant women who were at pre-natal monitoring in the ESF during data collection. For selection of the pregnant women, it was formed a stratified simple random sampling by raffle, as scheduling and setting a time of pregnant women in the pursuit of consulting the health unit. This type of sampling can be of two types: with and without replacement. For this study, it was adopted with replacement, in which the elements of the population may enter more than once in the sample, if the number drawn is the pregnant woman that is not in the health unit on the day of collection of the data.

The stratum are formed by the researcher according to the needs of the study, in this way, were represented by UBSF. For each stratum, by random techniques, were sampled in proportion to the total population contained in each one. For this, it is necessary to know beforehand the proportion of the population belonging to each one. The simple random sampling process makes use of the table of random numbers, so, all components of the population received a number. Next, it was determined the total sample components and through the table of random numbers, selected individuals to be searched.10

For the calculation of the sample, a survey was conducted by the Health Department of the municipality about the number of pregnant women registered in SISPRENATAL, distributed in 19 urban area UBSF, obtaining a total of 394 (N) pregnant women registered. After this survey was conducted a sample calculation of 30% (n) according to the population of each health unit, totaling 120 pregnant women. As the simple random
sampling with replacement through the raffle and taking into consideration the fluctuation due to the input and output of pregnant women in the program, it had a 119 forecast pregnant women to be searched.

As inclusion criteria: pregnant women enrolled in the Prenatal Program Units in aged equal to or greater than 20 years, literate, not submit mental problems and that accepted participating in the research, signing a Free and Informed Consent (FIC). The exclusion: women not enrolled in the Prenatal Program, under 20 years old, not literate and submit mental problems undermining the participation in the study.

Two instruments were used for data collection, being the WHOQOL-bref to assess the QOL of the pregnant woman and a form for the collection of demographic data, personal habits and current and obstetric antecedents of pregnant women. In order to facilitate the assessment of QOL, the World Health Organization (WHO) has compiled the WHOQOL-100. This is an instrument with 100 questions, being composed of six domains and 24 facets. In Brazil, the Portuguese version was developed at WHOQOL Center of the Department of Psychiatry and Legal Medicine of the Federal University of Rio Grande do Sul, coordinated by Dr. Marcelo Pio de Almeida Fleck.

Seen the need for short and swift implementation of instruments, the Group of quality of life of WHO developed an abbreviated version of WHOQOL-100, the WHOQOL-bref, with 26 questions. In this reduced version, every facet is represented by the sub item that most correlated with the overall score of the WHOQOL-100. Thus, the reduced domains are: physical, psychological, social relationships and environment. This instrument can be used to evaluate the QOL both healthy populations as people affected by loss and chronic disease.

In this study, we used the WHOQOL-bref, containing domains and facets contained in 26 issues applicable to low-risk pregnant women, i.e. those that do not have diseases that impair physical health. The first two questions assess the general QOL and that, calculated together generate a score of independent domains. The first refers to the QOL in general and the second to satisfaction with their own health. The remaining questions are distributed in four domains: physical, psychological, social relationships and environment.

The research was submitted to the Committee of Ethics in Research (CER) of Santa Maria College/PB and adopted with the Protocol of paragraph nº 633122010, respecting the Resolution 196/96 as regards the ethical aspects observed when conducting research involving humans. The search was only developed after the prior consent of the Secretary of Health of the Municipality of Sousa-PB by a letter of permission and signature of the FIC by respondent.

Prior to data collection, the subjects of the research were clarified on the goals of the study, how to apply and destination of the data. Were also informed of the willingness to participate, and may give up and join this study when they want, and the results treated with confidentiality, guaranteeing the anonymity of the information.

For data collection, pregnant women were selected by raffle in UBS, as scheduling for the prenatal consultation with the doctor or nurse, when on occasion were addressed and oriented on research. The data were collected from February to March 2011 by the master student and by volunteers trained and oriented to the implementation of the instrument, which is auto applicable, however, the master student and the volunteers were available for any clarification when fill out.

The data collected were organized into an electronic database of the Microsoft Excel application being coded, tabulated and presented in the form of tables and charts with their respective percentage distributions. The discussion was held on the basis of the literature review carried out previously, as a form of subsidy to discuss the results of this study.

RESULTS AND DISCUSSION

• Characterizing the sample

The group studied was distributed with greater concentration in the age group between 20 to 25 years; the marital status predominated women with regular partner (85%), among married women or those in stable Union and 15% had no fixed partners. As for occupation, 66% had household activities, 19% students and 15% had a paying job. As for household income, the majority (48.33%) of families of pregnant women received a minimum wage, 30% less than a minimum wage, 17.5% owned two-income salaries and only 4.17% had income from three to five minimum wages. Most women showed more than one pregnancy (58.33%), 50% was the first pregnancy. Of the total number of pregnant women, 21.66% had already aborted. The maximum number of pregnancies was of
six and a maximum of five children. Gestational age ranged from five to 39 weeks.

The data presented below are related to QOL of pregnant women measured through the WHOQOL-bref instrument. The answers of users were analyzed from a Likert-type scale of 1 to 5, where 1 and 2 correspond dissatisfaction, 3 to intermediate or neutral position, 4 and 5 satisfaction, including a positive assessment.

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The QOL for being considered a construct objective and subjective, can vary from person to person according to the optics of each one, therefore, most pregnant women (81.67%) considered their QOL as good, 16.67% did not present nor satisfaction or dissatisfaction and only 1.67% were not satisfied with their QOL. When asked about satisfaction with their health, 85.83 percent are satisfied and 3.33% are dissatisfied.

A similar study conducted with nursing professionals of a university hospital obtained 69.64% satisfaction to the WHOQOL-bref for question 01. A survey of community health agents (CHA) on assessment of QOL, 16.6% maintains neutral position of satisfaction and 5.3% reported being dissatisfied.

Among the areas examined, the third highest average physician obtained the percentage of satisfaction (64.40%) of QOL for pregnant women surveyed. With relation to dissatisfaction, this area also obtained the third highest average (11.90%). The physical domain shows the perception of pregnancy about their health condition, this contains the following facets: pain and discomfort, medication dependency, energy and fatigue, mobility, sleep and rest, everyday life activities and ability to work, according to Fig. 1.

Figure 1. Facets of the physical domain of the WHOQOL-bref. Sousa/PB-2012.

With regard to the physical domain, most pregnant women referred to mobility as the facet that showed the highest percentage of satisfaction (77.5%), followed by the activities of everyday life, (69.17%) and addiction treatment or medication (64.17%). Those that have lesser percentage revealing dissatisfaction were: pain, discomfort (20%), sleep, rest (17.5%), energy and fatigue (12.5%). Most pregnant women considered to be satisfied with their ability to locomotion. This allows the same can perform routine daily activities considered to be housewives. This result is similar with study conducted with nursing mothers, to refer that locomotion was considered satisfactory.

It is believed that the physical changes that occur in pregnancy as abdominal growth and difficulty sleeping, hindering sleep, feature of the third trimester of pregnancy, may be factors that contribute to the lack of energy. According to the nursing diagnosis, the fatigue is an oppressive feeling, sustained fatigue and inability to perform physical and mental activity.
The psychological domain has the second highest average percentage of satisfaction of pregnant women (70.41%). In this domain are discussed the positive and negative feelings that permeate the life of the pregnant woman, spirituality, perception about their body image and self-esteem. As for spirituality, 85.83% are satisfied. For women in gestation period the practice of religiosity and faith in God becomes stronger, since at this stage of their lives arise questions and existential doubts and one of the ways to treat her problems is to God.

Religiosity is determined by something is not seen, by an act of faith which modifies behavior and thoughts, overcoming all difficulties so unbelievable, becoming, in many cases, a support for the maintenance of life. For body image, satisfaction was found by the majority (66.67%). It was reported neutral position 19.17% and 14.17% dissatisfied with their body image. This result is similar to a study of pregnant women about body image referenced as good at 39.78% and 60.22% were dissatisfied. Gestation is a stage of life that occurs strong changes in the female body, although these are considered as a natural part of the pregnancy because women feel difficulties in accepting them, causing dissatisfaction, insecurity and even loss of identity prior to pregnancy.

High levels of self-esteem are important predictor of maternal competence. According to expert, the self-esteem relates to positive or negative evaluation that the individual makes himself. In this study, the majority of pregnant women (81.67%) is satisfied with her self-esteem. A study conducted in the city of Pelotas showed association of self-esteem with the Common Mental Disorder, showing that women with low self-esteem are more likely to mental disorders. These data corroborate with the findings of a study conducted in the northeastern region of Brazil, revealing that, teenage mothers, to provoke abortion, showed lower self-esteem when compared with those who interrupted pregnancy.

The domain social relationships showed the highest average (75.83%) of satisfaction. It refers to personal relationships, sexual activity and social support that pregnant women receive in the gravid period.
The facet sexual activity presented 64.17% of satisfaction, 10.0% neutral position and 25.83% of dissatisfaction with their sexual activity. These data show that not all pregnant women are satisfied with their sex life, corroborating with the literature to describe the sexual desire and female libido may decrease with the course of gestation, mainly in the 1st and 3rd quarters.25

Social support is critical to the development of the human being, particularly in periods of transition and changes that are necessary adjustments, as occurs with pregnancy. As can be seen, the social support is a way to offer help, both affective as a practice information. Social support can be evaluated by the interaction of the individual in their midst. An adequate social support provides support for pregnant women, favoring greater environmental control and autonomy, providing hope, support and protection.26

The domain environment showed lower percentage (43.33%) of satisfaction, result also found on literature17,27. This domain relates to how the expectant mother understand aspects related to the environment in which she lives.

Dissatisfaction in transport was evident in 26.67% of pregnant women. The municipality of Sousa has no public transportation, being the transport used the bike-taxi or motorcycle-taxi, or when the family has some kind of motorized vehicle. This result is similar with another study conducted with nursing mothers in that 24.8% reported dissatisfaction with regard to transportation.17

As to the satisfaction of the physical environment (pollution, climate, noise),
29.17% are satisfied, 48.33% maintains a neutral position and 22.5% are dissatisfied. Their responses reflect local housing conditions perceived by pregnant women as precarious, for need of basic sanitation and paving the streets.

In the evaluation of the environment domain, the environment in the home facet obtained the second highest average of satisfaction (66.67%), similar to literature, which was 60.3% of CHA' satisfaction in relation to the environment in the home. It agrees to infer that the environment at home is important, since it is the place where the person shares feelings of achievement, difficulties, joys and problems with the family, rest and considers as place of refuge of the tensions of everyday life.16

With regard to health services available, the majority (71.67%) demonstrated to be satisfied. For the participants, the prenatal care is important as well as the availability of health services provided, but not all have to be satisfied with the quality of the services offered (11.67%). Study with pregnant women shows that the greater the satisfaction with the prenatal care greater the QL scores for the areas health, functioning, psychological and spiritual.18

To show satisfaction with health services, the woman examines how is being treated and values the humanized assistance receiving health service.17 When the woman negatively evaluates this service, it reflects the inattention and disregard of the professionals working in these services.29

In a study30 the instrument used to measure the QOL was the WHOQOL-bref. As a result, the strengths of research refer to the use of an instrument known worldwide and recommended by w WHO to measure the QOL of people; inclusion of health workers of three distinct categories and, finally, to the seriousness of the researchers during the development and implementation of this.30

CONCLUSION

This study allowed the opportunity to describe the QOL of pregnant women by the facets which have highest rates of dissatisfaction, as well as meet socio-demographic aspects, and obstetric assistance that permeate the life of them. Characteristics of QOL measures by the WHOQOL-bref, two general questions of the instrument were considered satisfied, both for the QL and human health.

In the physical domain, the one that had a higher dissatisfaction were: pain, discomfort, sleep, rest, energy and fatigue. Those who have obtained the greatest satisfaction: mobility, activities of daily life and addiction treatment or medication.

In the psychological domain, facets that were highlighted as dissatisfaction were: memory and concentration, negative feelings, body image and appearance. As satisfaction were prevalent: spirituality and religion, negative feelings and self-esteem.

In the social relationship domain, there was a predominance of dissatisfaction in sexual activity, while personal relations gained greater satisfaction.

In the environmental domain, the facets: financial resources, participation and opportunity for recreation and transportation were cited as the most dissatisfied. Those who have obtained the greatest satisfaction were: health care, home environment, physical security and transportation.

It was noticed that, for each domain, had various facets with indexes of dissatisfaction. These results revealed that the attention of nurses is still very incipient as regards guidelines covering aspects related to QL. It is essential that nurses work in a holistic perspective and humanized quality involving the family in this process, encouraging active partner participation, promoting better preparation of these women for a healthy pregnancy.

In this study, it seeks to contribute to improving the quality of maternity care with information that will give grants for health professionals, especially nurses, to work in the areas of greatest weakness to these pregnant women.

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