SELF-ESTEEM AND QUALITY OF LIFE IN A SERIES OF PREGNANT WOMEN ATTENDED IN A PUBLIC HEALTH NETWORK*

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ABSTRACT: This paper aims to describe the self-esteem and quality of life levels of pregnant women attended in the public health network of Rio Branco, Acre. Three hundred and fifty-two pregnant women from the urban area with ≥ 35 weeks gestational age were interviewed in 2011. The Rosenberg Self-Esteem Scale and the World Health Organization Quality of Life (WHOQOL) Questionnaire were used in this study. The sample profile evidenced the following information on these women: 40.9% were in the 21-25 age range, 79.3% were single, 82.9% were non-white, 66.7% had secondary or higher education, 60.2% had family income lower than two minimum wages, 59.4% were multiparous and 85.5% wanted their current pregnancy. Lower self-esteem levels were found in unmarried pregnant women and those with greater economic status. In the physical domain, lower quality of life was noted among those above 30 years of age. Thus, during pregnancy, the presence of a partner and the economic status appear to influence women's self-esteem, while age influences their quality of life.
KEYWORDS: Pregnancy, Self-esteem, Quality of Life, Public Health.

AUTOESTIMA E QUALIDADE DE VIDA DE UMA SÉRIE DE GESTANTES ATENDIDAS EM REDE PÚBLICA DE SAÚDE

RESUMO: O objetivo foi descrever os níveis de autoestima e de qualidade de vida de gestantes atendidas na rede pública de saúde de Rio Branco, estado do Acre. Foram entrevistadas 352 gestantes da zona urbana, com idade gestacional ≥35 semanas, em 2011. Sendo empregada a Escala de Autoestima de Rosenberg e o Questionário de Qualidade de Vida da Organização Mundial de Saúde. O perfil da amostra foi de 21 a 25 anos (40,9%), solteiras (79,3%), não-brancas (82,9%), escolaridade ensino médio ou superior (66,7), renda familiar menor que dois salários mínimos (60,2%), multigestas (59,4%) e gravidez atual desejada (85,5). Menor autoestima foi apresentada pelas grávidas não-casadas e pelas de maior classificação econômica. Observou-se menor qualidade de vida, no domínio físico, entre aquelas acima de 30 anos. Assim, a presença de companheiro e a classificação econômica parecem influenciar a autoestima e a idade, a qualidade de vida, das mulheres no período gestacional.
DESCRITORES: Gravidez; Autoestima; Qualidade de vida; Saúde pública.

AUTOESTIMA Y CUALIDAD DE VIDA DE UNA SERIE DE GESTANTES ATENDIDAS EN RED PÚBLICA DE SALUD

RESUMEN: El objetivo fue describir los niveles de autoestima y de cualidad de vida de gestantes atendidas en la red pública de salud de Rio Branco, estado de Acre. Fueron entrevistadas 352 gestantes de la zona urbana, con edad gestacional ≥35 semanas, en 2011. Fue empleada la Escala de Autoestima de Rosenberg y el Cuestionario de Cualidad de Vida de la Organización Mundial de Salud. El perfil de la muestra fue de 21 a 25 años (40,9%), solteras (79,3%), no blancas (82,9%), escolaridad enseñanza media o superior (66,7), renta familiar menor que dos sueldos mínimos (60,2%), multigestas (59,4%) y gravidez actual deseada (85,5). Menor autoestima fue presentada por las embarazadas no casadas y por las de mayor clasificación económica. Se observó menor cualidad de vida, en el dominio físico, entre aquellas de más de 30 años. Así, la presencia de compañero y la clasificación económica parecen influenciar la autoestima, y la edad, la cualidad de vida de las mujeres en el periodo gestacional.
DESCRIPTORES: Gravidez; Autoestima; Cualidad de vida; Salud pública.

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INTRODUCTION

Pregnancy in women's lives results in major changes affecting various biopsychosocial aspects [1]. This is, therefore, a unique time in which every woman responds differently [2].

Pregnancy is a special period, but not for all women, since pregnancy and postpartum is a phase when a higher incidence of mental disorders occurs [3]. Susceptibility is related to family, marital, social, cultural and personality factors which impact on mother and child's health, with inter-relationship between changes and female self-esteem[3-5].

The term self-esteem is understood as the appreciation that the individual makes of himself with regard to his self-confidence and self-respect. It expresses an attitude of approval or rejection based on personal value judgments and observed through different behaviors and verbal reports that are predominantly affective[6].

The Rosenberg self-esteem scale is a widely used self-esteem evaluation tool[7-8]. In general, the scale assesses the attitude and the positive or negative feeling about oneself. Low self-esteem levels are related to the onset of mental disorders such as depression, anxiety and somatic complaints, which can have negative consequences in the mother-infant dyad interaction, as well as in child development[9].

In a study on pregnant women treated in the Unified Health System (SUS) in Pelotas, state of Rio Grande do Sul, the average Rosenberg self-esteem scale score was 9.2, highlighting the following positively associated variables: age, schooling and economic status. Negative associations were the perception of risk to the baby's health and the number of pregnancies. Moreover, high-risk pregnant women had high self-esteem when compared to those at low risk[5].

A survey conducted in the city of Juiz de Fora (MG) showed that mothers had a higher average self-esteem compared with non-mothers. Thus, despite the pregnancy resulting in a lower average self-esteem after the forming of the emotional bond between mother and child, self-esteem tends to improve[10]. However, another study revealed that teenage pregnancy resulted in reduced self-esteem[11].

Besides self-esteem, the meaning of quality of life during the pregnancy cycle remains little known. However, there are many factors that contribute to increased quality of life. Among them, one can highlight sexual health promoting improvement in the couple's relationship[2]; self-knowledge, allowing the pregnant woman to understand the time being experienced; and family relationships, which provide affective and well-being contributions[7,12].

In Brazil, especially in the Amazon region, there are few studies on self-esteem and quality of life during pregnancy. This study, therefore, aims to describe the self-esteem and quality of life levels in a number of pregnant women treated in a public health network in Rio Branco, Acre.

METHOD

This is a quantitative cross-sectional study conducted with third-trimester pregnant women treated in the public health network in Rio Branco, Acre, from March to May 2011. Women in their 35th gestational week and over, aged 16 and over, with a partner, experiencing a low-risk pregnancy identified in prenatal care and living in the urban area were included in the sample.

The convenience sample was selected in health facilities (Health Centers and Family Health Units) and maternity units among pregnant women meeting the inclusion criteria of the study.

The self-esteem measurement tool used was the Rosenberg Self-Esteem Scale, validated by Dini[13]. It consists of ten statements, each with four-response options ranging from zero to three, i.e. from "agree" to "strongly disagree". Thus, the scale's final score can vary from zero (better self-esteem) to thirty (worse self-esteem).

The World Health Organization Quality of Life WHOQOL-Bref Questionnaire, widely used in different countries and translated into 20 languages, was used to evaluate the quality of life. Available in Brazil, it takes stock of the activities developed over the last two weeks and comes in two versions, the long version (100 questions) and the short version (26 questions). The latter was applied in this research and the best physical, psychological, social and environmental psychometric performance was drawn from the questions[14].

The WHOQOL-Bref's physical domain obtains information about pain and discomfort, energy

and fatigue, sleep and rest, mobility, daily living activities, drug or treatment dependence and working capacity. The psychological domain picks up information about positive feelings; thinking, learning, memory and concentration; self-esteem, body image and appearance; negative feelings; spirituality, personal beliefs and religion. The information to be obtained in the social domain refers to social relationships, social backing (support) and sexual activity. The environmental domain gathers information about physical safety and protection; home environment; financial resources; health and social care: accessibility and quality; opportunities to acquire new information and skills; participation in and/or opportunities for recreation and leisure; physical environment (pollution, noise, traffic and climate) and means of transportation.

The WHOQOL-Bref is a self-applicable questionnaire and the respondent shows his answer through scores ranging from one to five, with the worst condition score being one and the best five. The domains' results' scores range from zero to one hundred, the worse being the closest to zero and best those nearest to one hundred. Thus, a respondent with a score of 50 for a given domain may be considered average for that domain.

Participants also answered questions to characterize the socioeconomic and demographic profile. Their marital status was divided into married (legally married) and unmarried (stable or unstable relationship). It is noteworthy that interviews were conducted in a special separate room within health units, with the pregnant women who met the selection criteria and who signed the Informed Consent Form. The procedure followed the provisions of Resolution 196/96 of the National Health Council and was approved by the Research Ethics Committee, Federal University of Acre, under protocol. 23107.017408/2010-16.

The absolute and relative frequency, the means and the standard deviation for continuous variables were initially obtained for data analysis. Next, the means of self-esteem's score against independent variables (age, skin color, marital status, schooling, employment, monthly household income, economic status, head of household, number of pregnancies, weight gain, current pregnancy, smoking and drinking) were obtained and compared with the means of self-esteem and quality of life's scores through the Student t test. The mean and standard deviation for the standardized scores of the domains of the WHOQOL-Bref protocol were also calculated. The confidence interval (CI) used in the analysis was 95%. Data processing and analysis were performed using the SPSS statistical package, version 17 for Windows.

RESULTS

Three hundred and fifty-two pregnant women participated in this study, mostly aged between 21 and 30 years (66.5%), non-white, unmarried, educated to secondary school level or higher, unemployed or with household income of less than two minimum wages, resulting in economic class C, D and E according to the Brazilian Association of Research Companies (ABEP) (Table 1).

In most households, the partner was the head of the family. Pregnant women were multiparous and showed weight gain of up to 15 kg. Of the respondents, 25.3% achieved a weight gain greater than 15 kg and 14.5% said their current pregnancy was unwanted. Smoking and drinking habits were evidenced in 8% and 10.2% of pregnant women, respectively.

While analyzing self-esteem in pregnant women, those unmarried and belonging to economic class A/B had the lowest self-esteem. The remaining variables were not statistically significant; however, it is worth mentioning that lower self-esteem was found among pregnant women aged ≤ 30 years, white, with schooling up to elementary school, unemployed, multiparous, with weight gain over 15 kg, unwanted current pregnancy, smokers and drinkers (Table 2).

Regarding the quality of life domains, the highest mean was obtained for physical (75 points; σ ± 11.6), followed by social (74 points; σ ± 12.4) and psychological (73.3 points; σ ± 105.6). The lowest score was observed in the environmental domain (60.8 points; σ ± 59.4), which is the value with greater distance from the other domains. There were no differences in the quality of life domains between the categories of independent variables, except the physical, which suffered some influence due to the age of the pregnant women ($p > 0.05$) (Table 3).

Table 1 – Socioeconomic, pregnancy and lifestyle characteristics of a number of third-trimester pregnant women. Rio Branco, 2011

Variables	N	%
Age (years)		
16 to 20	89	25,3
21 to 25	144	40,9
26 to 30	90	25,6
31 to 35	29	8,2
Skin color		
White	60	17,1
Non-white	292	82,9
Marital Status		
Married	73	20,7
Unmarried	279	79,3
Schooling		
Elementary School	117	33,3
Secondary / Higher Education	235	66,7
Employed		
Yes	111	31,5
No	241	68,5
Monthly Household income in minimum wage (MW)		
< two MW	210	60,2
≥ two MW	139	39,8
Economic Class (ABEP)		
A/B	29	8,2
C/D/E	323	91,8
Head of Family		
Partner	309	87,8
Other	43	12,2
Number of pregnancies		
Primiparous	143	40,6
Two and over	209	59,4
Weight gain (Kg)		
Up to 15	263	74,7
16 and over	89	25,3
Current Pregnancy		
Wanted	301	85,5
Unwanted	51	14,5
Smoker		
Yes	28	8
No	324	92
Drinker		
Yes	36	10,2
No	316	89,8
Total	352	100

Table 2 – Self-esteem mean and standard deviation according to variables of a number of pregnant women. Rio Branco, 2011

Variables	Self-esteem (Rosenberg scale)		
	X	dp	p
Age (years)			
≤ 30	8,65	3,96	0,181
> 30	7,59	4,98	
Skin color			
White	9,02	4,07	0,342
Non-white	8,47	4,06	
Marital Status			
Married	7,21	4,03	<0,001
Unmarried	8,92	4,06	
Schooling			
Elementary School	9,01	4,06	0,152
Secondary / Higher Education	8,34	4,04	
Employed			
Yes	8,23	4,04	0,303
No	8,71	4,06	
Monthly Household income			
< two MW	8,76	4,06	0,564
≥ two MW	8,51	4,04	
Economic Class (ABEP)			
A/B	8,67	4,06	0,050
C/D/E	7,34	3,97	
Head of Family			
Partner	8,57	4,06	0,931
Other	8,51	4,05	
Number of pregnancies			
Primiparous	8,33	4,08	0,372
Two and over	8,72	4,04	
Weight gain (Kg)			
Up to 15	8,45	4,06	0,375
16 and over	8,90	4,03	
Current Pregnancy			
Wanted	8,12	4,00	0,404
Unwanted	8,64	4,06	
Smoker			
Yes	8,64	4,07	0,912
No	8,55	4,04	
Drinker			
Yes	9,36	4,07	0,210
No	8,47	4,04	
Total	8,56	4,07	

Table 3 – Quality of life, per mean and standard deviation of independent variables, of a number of pregnant women. Rio Branco, 2011

Variables	Quality of Life (WHOQOL-Bref)											
	Physical			Psychological			Social			Environmental		
	X	Σ	p	X	σ	p	X	σ	p	X	Σ	P
Age (years)												
≤ 30	75,4	11,68	0,044	73,4	10,49	0,446	74,9	12,65	0,503	61,1	10,34	0,139
> 30	70,8	10,33		71,8	10,19		73,3	10,05		58,1	11,16	
Skin color												
White	75,5	12,59	0,717	74,0	10,78	0,571	73,9	13,24	0,551	61,0	11,46	0,864
Non-white	74,9	11,45		73,1	10,41		74,9	12,30		60,8	10,22	
Marital Status												
Married	74,6	10,04	0,760	71,9	8,41	0,200	75,1	9,37	0,787	61,4	9,13	0,610
Unmarried	75,1	12,03		73,6	10,92		74,7	13,15		60,7	10,75	
Schooling												
Elementary	73,9	12,15	0,220	72,9	11,60	0,681	73,7	12,93	0,267	59,9	11,20	0,229
Secondary / Higher Education	75,5	11,35		73,4	9,87		75,3	12,20		61,3	10,01	
Employed												
Yes	75,1	12,35	0,926	73,5	10,43	0,772	75,3	12,61	0,584	60,9	11,23	0,910
No	74,9	11,31		73,2	10,50		74,5	12,40		60,8	10,06	
Monthly Household income												
< two MW	75,6	10,76	0,202	73,3	10,93	0,833	75,0	13,52	0,605	60,6	10,90	0,875
≥ two MW	74,0	12,23		73,0	9,68		74,3	10,80		60,8	9,31	
Economic Class (ABEP)												
A/B	75,9	11,52	0,670	72,0	11,02	0,493	74,7	13,99	0,982	62,6	11,86	0,339
C/D/E	74,9	11,66		73,4	10,42		74,8	12,33		60,7	10,29	
Head of Family												
Partner	72,0	17,97	0,234	71,8	12,85	0,330	76,7	16,42	0,388	61,2	12,41	0,809
Other	75,4	10,43		73,5	10,09		74,5	11,80		60,8	10,14	
Number of pregnancies												
Primiparous	74,9	12,74	0,942	72,6	10,15	0,315	75,4	13,96	0,422	60,9	10,30	0,862
Two and over	75,0	10,84		73,7	10,67		74,3	11,32		60,8	10,53	
Weight gain (Kg)												
Up to 15	75,8	12,34	0,464	73,8	12,60	0,633	75,7	13,77	0,435	61,9	11,43	0,262
16 and over	74,7	11,40		73,1	9,66		74,5	11,98		60,5	10,06	
Current Pregnancy												
Wanted	75,3	10,58	0,384	73,4	9,64	0,536	75,3	11,36	0,166	60,7	10,24	0,519
Unwanted	73,2	16,57		72,1	14,49		71,7	17,41		61,7	11,52	
Smoker												
Yes	74,9	14,95	0,960	74,9	12,29	0,402	76,8	14,93	0,371	60,8	10,81	0,998
No	75,0	11,33		73,1	10,30		74,6	12,23		60,8	10,41	
Drinker												
Yes	71,9	21,40	0,352	70,0	15,62	0,183	76,6	20,68	0,559	62,7	14,54	0,414
No	75,3	9,94		73,6	9,67		74,6	11,17		60,6	9,86	
Total	75,0	11,6		73,3	10,5		74,8	12,4		60,8	59,4	

DISCUSSION

Pregnancy is a unique and special time in a woman's life. On taking on the identity of becoming a mother, feelings may shift between joy and uncertainties, fears and security or insecurity[15].

Since ancient times, beliefs have linked pregnancy to the female figure[16], causing the redefinition of values, esteem and identity[12], requiring constant adaptations by pregnant women because of internal and external changes[17] during pregnancy.

Self-esteem is one of pregnant women's psychological assessment topics that is little studied[9]. A mother's high self-esteem is a protective factor in child development and against depression during and after pregnancy[18-19].

Age is a risk factor for low self-esteem in pregnant women and has been observed in adolescents[20-21]. A survey conducted in Pelotas, Rio Grande do Sul found that women under 18, unmarried, with a low educational level, current unplanned pregnancy, multiparous and who used any drug had lower self-esteem[5]. Although not referring specifically to the group of teenagers, the present study cites similarities in the findings among women aged 30 years or less.

The mean self-esteem of women from Pelotas, Rio Grande do Sul was 9.3 points[9], which is higher than that found in pregnant women of Rio Branco, showing that the former had greater self-esteem.

Marital status during pregnancy showed a significant difference in self-esteem, with the worst level of self-esteem being found in unmarried women, a fact that may be associated with security achieved through traditional marriage[22]. Partners are a source of support and reassurance to pregnant women and can increase their self-esteem through their attention and tenderness during pregnancy and childbirth. They are also responsible for assisting in controlling and reducing the feeling of pain. Participation of men throughout the process is new and stems from the struggle for the humanization of care for pregnant women[23]. It is worth mentioning that the lack of spousal support to look after the baby was also associated with low self-esteem in pregnant women[24]. A study conducted in a Family Health facility in Recife, in the state of Pernambuco, showed that there is low paternal involvement in the prenatal period[25].

A study to assess factors associated with symptoms of depression in pregnant women showed that the unstable marital status or absence of a partner, lack of social support and unplanned pregnancy were considered risk factors for the onset of these symptoms[26].

The women surveyed ranked with socioeconomic status A/B had a lower self-esteem, which may be associated with the physical and behavioral changes related to pregnancy. However, no studies were found in the literature to corroborate this finding.

Pregnancy's physiological changes can affect the way women perceive their quality of life and health[27]. Thus, prenatal care is an important tool for maintaining the quality of life during pregnancy since it allows a comprehensive and expanded view of pregnant women [8]. The individual characteristics of each woman and those related to sociodemographic conditions may interfere with the development of a healthy pregnancy, thus altering their quality of life[7,28]. The pregnant women surveyed had significant differences in this domain due to their age.

In a study conducted on the quality of life with 120 pregnant women in the municipality of Sousa, in the state of Paraíba, dissatisfaction of the physical domain was expressed as pain, discomfort, fatigue, changes in sleep and rest patterns and lack of energy. The psychological domain emphasized changes in body image and appearance, memory, concentration and negative feelings. Dissatisfaction in the social domain was related to sexual activity. Regarding the environmental domain, the greatest dissatisfaction elements were reported as financial resources, recreational opportunities and transportation[29].

In the number of pregnant women of this study, domains with lower scores of quality of life were recorded in the environmental and psychological domains. A study on 42 pregnant women from a Family Health facility on the outskirts of São Bernardo do Campo, state of São Paulo found mean domain scores of 57.65 for physical, 68.75 for psychological, 59.75 for environmental and 77.98 for the social domain of quality of life [8], with observed values close to those found in this study for the environmental and social domains.

A study undertaken with a group of diabetic and non-diabetic women in Botucatu, state of São Paulo revealed that both diabetic and normoglycemic

women in late pregnancy had lower scores for all quality of life domains compared to pregnant women in this study, except for the environmental domain[30]. Another study on water exercise and quality of life, conducted in Campinas, also in the state of São Paulo, women at 36 weeks of gestation scored around 67 points in the physical domain and 60 points in the environmental domain, with an overall mean close to 70 points[31], demonstrating, with respect to the environmental domain, similarity with that seen among pregnant women in this study, with the quality of life better perceived in the remaining domains.

A clinical trial held at the Comprehensive Women Health Care Center of the Federal University of Campinas, also on physical exercise and quality of life showed that, in late pregnancy, all quality of life domains scored below 70 points, with lower scores in the group of women not practicing physical exercise, with 42 and 55 points in the physical and environmental domains, respectively[32].

It follows, then, that this and other investigated studies have demonstrated the environmental domain's tendency to achieve the lowest scores among pregnant women when it comes to quality of life and is related to one or some of the following variables: physical security and protection; home environment; financial resources; health and social care: accessibility and quality; opportunities to acquire new information and skills; participation and/or recreational and leisure opportunities; physical environment (pollution, noise, traffic and weather) and means of transportation.

A limiting factor to this study is that data cannot be generalized to all pregnant women because it is a convenience sample. However, they allow the understanding of individual aspects and the exposure of the weakest variables during pregnancy. It is worth mentioning that, even with a small number of pregnant women, the study allowed coverage of all the Primary Health Care facilities of Rio Branco, Acre.

CONCLUSION

This study found that unmarried pregnant women and those ranked under economic status A and B had the lowest self-esteem levels. In addition, lower self-esteem scores were observed among women with younger ages, with low schooling, unemployed status, with a weight gain above 15 kg, with previous pregnancies, current unwanted pregnancy and alcohol and tobacco use. As for the quality of life, the lowest scores of quality of life were obtained in the psychological and environmental domains, with the physical domain showing differences for the ages analyzed.

It is worth noting that this study should be seen as an initial approach to the issue of maternity consequences on self-esteem and quality of life of women. It would therefore be interesting to conduct further research involving larger population samples, since developing a better understanding of the relationship between pregnancy and self-esteem / quality of life is a need for maintaining the health of mother and fetus.

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