Chapter 13

Comparison between the quality of life, anxiety and depression of pregnant women who live in rural and urban area in a municipality in the Brazilian Amazon

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ABSTRACT

This study aimed to compare pregnant women living in rural and urban areas in a municipality in the Amazon region, in relation to quality of life, levels of common mental disorders, stress and anxiety. A descriptive, exploratory research. A sample of 23 pregnant women attended at a health center in the city of Ouro Preto do Oeste-RO, where interviews were conducted with pregnant women, applying 04 instruments: Sociodemographic, Depression, Anxiety and Stress Scale - Short Form (DASS- 21), World Health Organization Quality of Life (WHOQOL-BREF) and Self-Reporting Questionnaires (SRQ). It was observed that the sociodemographic profile of pregnant women is similar in all variables studied. In relation to the common mental disorder, it was not possible to detect alterations, where all presented normality patterns. In the same sense, when the levels of anxiety, stress and depression were evaluated by DASS21, there were no significant changes. However, the quality of life of pregnant women in urban areas was below that of pregnant women in rural areas, that is, those from urban areas have a worse quality of life in the psychological and social facets. Obtaining information on the pregnant women's profiles is essential to carry out actions to promote their health and also ensure a healthy pregnancy for the pregnant woman and her child.

Keywords: Pregnant Woman, Quality of life, Anxiety, Depression, Common mental disorder

1 INTRODUCTION

According to the SIAB (Primary Care Information System) of the Ministry of Health, Brazil has about 657.27 cases/100,000 pregnant women per year. Of these, 100,547 cases are pregnant women between 10 and 19 years old; and 651,691 cases of pregnant women over 20 years of age. This survey is generated through the work of Family Health teams and Community Health Agents, who carry out the registration of these families (Brasil, 2013). There are no exact data on the number of pregnant women in the northern region or in the state of Rondônia, as the program used by the Brazilian government, DataSUS, only estimates the number of live births.

Among the complications preceding or during pregnancy, obesity and pregnancy-related symptoms are the main factors linked to a decrease in the quality of life of pregnant women. Quality of life encompasses a multidimensional character, which encompasses psychological, physical and social conditions, which portrays the life experience of each individual (Gadelha, et.al. 2020). Naseem et. al. (2011), in a study carried out to compare the mental and physical health of pregnant women living in rural and urban areas, identified that rural pregnant women had greater role limitations due to physical problems, general perceptions of health and emotional problems than women pregnant women residing in urban areas; proving in their study that pregnant women living in urban regions have a better self-perception of mental and physical health than those living in rural areas.

The period of pregnancy is a process of transformations in which the woman experiences, over the course of nine months, moments in which identity changes and a new definition of the woman's role are involved. When it comes to primiparous women, the change is more abrupt, because, in addition to the role of daughter, woman, she now occupies a space that is being a mother. The changes and perceptions of the pregnant woman, until the arrival of the baby, will favor the adaptation of the pregnant woman, considering that the whole process generates expectations and anxieties, which in this period are very common (Pio & Capel, 2015).

Studies carried out have observed that many pregnant women who maintained a more "healthy" diet, opting for foods such as salads, cereals, fish, unprocessed meat and vegetables, had a lower risk of developing anxiety, when compared to those who maintained a diet with western habits. , consuming processed meat, industrialized foods based on vegetable oils and a higher consumption of carbohydrates (Gomes, et.al. 2019). Therefore, to maintain the quality of life during pregnancy, it is necessary to make good choices regarding eating habits. Therefore, when evaluating maternal morbidity and mortality rates in Brazil, it is identified that even with all the advances available in medicine, these rates remain very high. Therefore, it is observed how important prenatal care is to improve and promote quality of life during pregnancy and postpartum (Oliveira, et.al. 2016).

The presence and direct action of the nurse in prenatal care is essential for the pregnancy to run smoothly, so the professional must be qualified to meet the demands and needs of pregnant women in their pregnancy period. The nursing professional is the main agent in relation to the orientation of the pregnant

woman in her prenatal care, solving her doubts, guiding her regarding the need and importance of exams and consultations. From the moment that the reception of pregnant women is humanized, it favors trust and monitoring regarding possible intercurrences, which are identified early as anxiety and depression. With this, it improves the quality of life of the pregnant woman in the pregnancy period (Dias, et.al., 2018).

Thus, the aim of this study was to compare the profile of pregnant women living in rural and urban areas in relation to levels of depression, stress and anxiety with quality of life in a municipality in the Amazon region.

2 METHODOLOGY

This is a descriptive, cross-sectional exploratory study. The population consisted of pregnant women residing in the municipality of Estância Turística Ouro Preto do Oeste - Rondônia, attended at a Health Center by two teams of the Family Health Strategy. The sample consisted of 23 pregnant women who performed their prenatal care at the Bela Floresta Health Center, in this municipality. The data collection period was from May 2021 to September 2021.

The municipality of Estância Turística de Ouro Preto do Oeste is located in the central region of the state of Rondônia, in the northern region of Brazil, and is part of the Amazon region. In the last census, carried out in 2010, a population of 37,928 people was estimated, of which 5,157 are women residing in rural areas and 4,591 residing in urban areas. The population with nominal monthly income per capita of up to 1/2 minimum wage in approximately 35.5%, presented a Human Development Index - HDI of 0.682 (IBGE, 2011). There are no records of pregnant women and/or pregnancies in recent years, at the state and municipal levels.

The collections were made after the pregnant women's routine consultations, where they were invited to participate in the study and if they accepted, they signed the Free and Informed Consent Form (TCLE) and were interviewed. There were 04 instruments used in the interviews, the first being the sociodemographic, the second the Self-Reporting Questionnaires (SRQ-20), the third the Depression, Anxiety and Stress Scale (DASS-21) and the fourth instrument evaluated the quality of life of pregnant women, for this purpose the World Health Organization Quality of Life (WHOQOL-BREF) was chosen.

The SRQ is a self-administered instrument, containing a dichotomous scale (yes/no) for each of its questions. Neurotic symptoms assessed by the 20-item version of the SRQ (SRQ-20) are similar to common mental disorders (CMD), 4 which are characterized by non-psychotic symptoms such as insomnia, fatigue, irritability, forgetfulness, difficulty concentrating and somatic. Since the cutoff point is 7 (Harding, et al., 1980; Santos, et. al., 2010).

The short version of the 21-item Depression, Anxiety and Stress Scale - Short Form (DASS-21) allows you to assess states of depression, anxiety and stress. However, this version has the properties that attest to its quality to assess emotional states. (Apostle, et. al. 2006). It consists of 26 questions (questions number 1 and 2 are about general quality of life), the answers follow a Likert scale (from 1 to 5, the higher

the score, the better the quality of life). Apart from these two questions (1 and 2), the instrument has 24 facets which make up 4 domains which are: physical, psychological, social relations and environment. Questions 1 and 2 should appear as follows: 1 – perception of quality of life (average result of 1 to 5); 2 – satisfaction with health (mean result 1 to 5). For each facet, just add the interview values (from 1 to 5) and divide by the number of participants. Then it is necessary to make an average where the result will be from 1 to 5.

The WHOQOL-BREF instrument was used to assess the quality of life of pregnant women, where it consists of 26 questions, which are divided into 4 domains: environment, physical, social relationships and psychological, in addition to also assessing the quality of life general and contain 24 facets that make up each domain. With the use of this instrument, it is possible to identify the dimension or domain that has the most negative and positive evaluations, from the pregnant woman's point of view (Castro, & Fracolli, 2013).

The interviews were carried out by the main researcher and the team (nurse and nursing technician) who were part of the Bela Floresta/RO health center, on a voluntary basis. Remembering that the UBS team was aware of the research that was carried out, and those who participated in the interviews received training for the correct application of the instruments.

The information obtained from the documents was tabulated in spreadsheets in the Microsoft Excel version 2019 program and after, analysis was performed in the Statistical Package For Social Science For Windows (SPSS) version 21 program. A significance level of $p<0.05$ was adopted.

The study was carried out within the ethical standards required by Resolution Nº 466/12 of the National Council for Ethics and Research, which deals with fundamental ethical and scientific requirements with human beings, aiming to ensure the rights and duties that concern the participants. The project was approved by the Research Ethics Committee of the Lutheran University of Brazil via Plataforma Brasil, under CAAE: 44261421.0.0000.5349 and Opinion number: 4.616.012. All pregnant women in the study signed the Free and Informed Consent Form (TCLE), with 02 copies available, one for the participant and another for the researcher.

3 RESULTS AND DISCUSSION

The results to be presented in this study compare pregnant women from the Amazon region of the municipality of Estância Turística de Ouro Preto do Oeste, located in the state of Rondônia, Brazil, and who live in rural and urban areas. Aiming to compare the profile of pregnant women living in rural and urban areas in relation to the levels of common mental disorder, stress and anxiety with the quality of life in a municipality in the Amazon region.

Table 1. Comparison of the sociodemographic profile of 23 pregnant women living in rural and urban areas who were undergoing prenatal care at the Bela Floresta Health Center, in the town of Estância Turística de Ouro Preto do Oeste/RO, Brazil.

Variáveis	Countryside (n=9; 39,1%)	Urban area (n=14; 60,9%)	p
Age (years) - mean ± SD	26,1 ± 6,2	26,4 ± 5,7	0,923
Skin color – n (%)			0,688
white	1 (11,1)	1 (7,1)	
brown	8 (88,9)	12 (85,7)	
black	0 (0,0)	1 (7,1)	
Level of education - n (%)			0,628
Complete Elementary	2 (22,2)	1 (7,1)	
incomplete high school	0 (0,0)	1 (7,1)	
full medium	5 (55,6)	6 (42,9)	
Incomplete higher	1 (11,1)	2 (14,3)	
Graduated	1 (11,1)	4 (28,6)	
Marital Status - n (%)			0,340
Single	1 (11,1)	5 (35,7)	
Married/Stable union	8 (88,9)	9 (64,3)	
Performs paid work/activity - n (%)			**0,009**
At the	8 (88,9)	4 (28,6)	
yes	1 (11,1)	10 (71,4)	
Monthly income - n (%)			0,250
None	3 (33,3)	1 (7,1)	
Until 1 s.m.	3 (33,3)	9 (64,3)	
1 a 2 s.m.	3 (33,3)	3 (21,4)	
2 a 3 s.m.	0 (0,0)	1 (7,1)	

Source: Prepared by the author, 2021.

The epidemiological data of pregnant women in the urban area are similar to those of pregnant women in the rural area, as shown in Table 1. Except in relation to paid work, where 71.4% of pregnant women in the urban area have paid work, while only 11. 1% of pregnant women in rural areas have paid work.

Table 2. Comparison of the results of the Self-Reporting Questionnaire (SRQ-20) instrument between pregnant women living in rural and urban areas and who performed prenatal care at the Bela Floresta Health Center, in the municipality of Estância Turística de Ouro Preto do Oeste /RO, Brazil.

Items	Countryside (n=9; 39,1%) n (%)	Urban area (n=14; 60,9%) n (%)	p
Frequent headaches	4 (44,4)	4 (28,6)	0,657
Lack of appetite	3 (33,3)	1 (7,1)	0,260
sleeps badly	2 (22,2)	6 (42,9)	0,400
Get scared easily	7 (77,8)	5 (35,7)	0,089
hand tremors	0 (0,0)	1 (7,1)	1,000
Feel nervous or tense or worried	6 (66,7)	7 (50,0)	0,669
Indigestion	2 (22,2)	2 (14,3)	1,000
Difficulty thinking clearly	2 (22,2)	5 (35,7)	0,657
been feeling sad lately	1 (11,1)	3 (21,4)	1,000
Has been crying more than usual	3 (33,3)	7 (50,0)	0,669
Finds it difficult to perform their daily activities with satisfaction	2 (22,2)	4 (28,6)	1,000
Has difficulty making decisions	2 (22,2)	6 (42,9)	0,400
Have difficulties with the service	0 (0,0)	0 (0,0)	-
Is unable to play a useful role in your life	0 (0,0)	1 (7,1)	1,000
Has lost interest in things	1 (11,1)	2 (14,3)	1,000
You feel like a useless, worthless person	1 (11,1)	2 (14,3)	1,000
Have you had thoughts of ending your life	0 (0,0)	1 (7,1)	1,000
Feel tired all the time	3 (33,3)	8 (57,1)	0,300
Have unpleasant sensations in the stomach	2 (22,2)	6 (42,9)	0,400
You get tired easily	5 (55,6)	9 (64,3)	1,000
Total SRQ - median (min-max.)	3 (1-13)	5 (1-16)	0,336

With symptoms of a non-psychotic mental disorder (≥ 7 points)	2 (22,2)	5 (35,7)	0,657

Source: Prepared by the author, 2021.

There was no significant difference between pregnant women in rural and urban areas regarding manifestations of common mental disorders assessed by the SRQ (Table 2). However, 22.2% of pregnant women were found in the rural area, while in the urban area it was 35.7% with CMD symptoms. Although the other instrument parameters are quite similar between the two investigated populations, those who live in urban areas have a higher number of pregnant women with CMD symptoms.

Table 3. Comparison of the Depression, Anxiety and Stress Scale - Short Form (DASS-21) instrument between pregnant women living in rural and urban areas and who underwent prenatal care at the Bela Floresta Health Center, in the municipality of Estância Turística from Ouro Preto do Oeste/RO, Brazil.

Domains	**Countryside (n=9; 39,1%) n (%)**	**Urban area (n=14; 60,9%) n (%)**	**p**
Stress- median (min-max.)	16 (2-20)	10 (2-34)	0,877
Stress Level Classification			0,361
Normal	3 (33,3)	8 (57,1)	
Light	4 (44,4)	2 (14,3)	
Moderate	2 (22,2)	3 (21,4)	
Severe	0 (0,0)	1 (7,1)	
Anxiety - median (min-max.)	8 (0-22)	5 (2-10)	0,141
Anxiety Level Classification			0,077
Normal	2 (22,2)	9 (64,3)	
Light	3 (33,3)	0 (0,0)	
Moderate	2 (22,2)	4 (28,6)	
Severe	1 (11,1)	1 (7,1)	
extremely severe	1 (11,1)	0 (0,0)	
Depression – median (min-max.)	4 (0-10)	3 (0-18)	0,781
Depression Level Classification			0,688
Normal	8 (88,9)	12 (85,7)	
Light	1 (11,1)	1 (7,1)	
Moderate	0 (0,0)	1 (7,1)	

Source: Prepared by the author, 2021.

Regarding the DASS21, there was also no statistically significant difference between the two investigated populations, although the higher prevalence of normality in women from the urban area stands out, both for stress and anxiety (Table 3).

Table 4. Data on the quality of life assessed by the WHOQOL-BREF instrument, among pregnant women living in rural and urban areas and who performed prenatal care at the Bela Floresta Health Center, in the municipality of Estância Turística de Ouro Preto do Oeste /RO, Brazil.

Domínios WHOQOL-BREF	**Zona rural (n=9; 39,1%) Média ± DP**	**Zona urbana (n=14; 60,9%) Média ± DP**	**p**
Physicist	81,0 ± 15,6	70,9 ± 9,8	0,110
Psychological	83,3 ± 4,7	73,2 ± 10,2	**0,004**
Social	91,7 ± 13,2	68,5 ± 24,3	**0,008**
Environment	79,2 ± 10,8	74,1 ± 11,3	0,298
Total	86,1 ± 13,2	77,7 ± 17,1	0,223

Source: Prepared by the author, 2021.

Regarding quality of life, pregnant women in rural areas had significantly higher scores in the psychological and social domains. In the other dimensions, it is observed that pregnant women from rural areas have better scores in terms of physical, environmental and total, although no significant differences are shown (Table 4).

Table 5. Association between the instruments applied, the SRQ and DASS21, with the quality of life scores comparing pregnant women living in rural and urban areas, through Pearson's correlation coefficient.

	WHOQOL-BREF				
Scales	**Physicist**	**Psychological**	**Social**	**Environment**	**Total**
SRQ					
Countryside	**-0,744***	-0,438	0,055	-0,343	-0,215
Urban area	-0,125	**-0,694****	-0,307	-0,047	-0,078
DASS21					
Stress					
Countryside	-0,024	0,276	-0,365	-0,382	0,272
Urban area	0,426	-0,367	0,304	0,302	0,112
Anxiety					
Countryside	**-0,763***	-0,464	-0,117	-0,507	-0,207
Urban area	0,229	-0,026	0,022	0,166	-0,115
Depression					
Countryside	-0,308	-0,366	0,345	-0,184	-0,057
Urban area	-0,066	**-0,720****	-0,409	-0,004	0,153

Source: Prepared by the author, 2021.

In rural women, there was a statistically significant inverse association between scores in the physical domain and the SRQ and DASS21 – Anxiety, that is, the higher the SRQ and anxiety scores, the lower the quality of life score in the Physical domain. In women from the urban area, there was a statistically significant inverse association between scores in the psychological domain with the SRQ and DASS21 – Depression, that is, the higher the SRQ and depression scores, the lower the quality of life score in the Psychological domain.

In a study carried out with 330 pregnant women, in a city in the central region of Brazil, the SRQ-20 instrument was applied, where the mean score was 7.74. Therefore, those who answered YES to the questions with the highest prevalence were: feeling nervous, tense or worried (73.9%), with the second highest answer being, you get tired easily (62, 3%) (Lucchese, et. al. 2017). In another study by Lucchese, et. al. (2014), in which the focus researched were people from the community in general, in a medium-sized municipality in the central-west region of Brazil, when applying the same instrument, the SRQ-20, a score between 5.59 and 5.35 points. Comparing with this study, it was observed that 22.2% of pregnant women in the rural area had symptoms of non-psychotic mental disorder, while in the urban area 35.7%, with a score ≥7. It was observed that in relation to this sample the number of pregnant women with symptoms of non-psychotic mental disorder is low.

In a survey carried out in rural Ethiopia, the same SRQ-20 questionnaire was applied to pregnant women, with the highest rate of YES responses to the questions "Have you been feeling sad lately", "Do you have frequent headaches" and "I lost my interest in things", indicating higher levels of propensity for

anxiety and depression (Hanlon, et. al. 2008). Regarding this study, no significant differences were found in these feelings, as shown in Table 2, indicating that the two populations are quite similar.

Studies corroborate the need for a critical look in order to understand the variables on the mental health of pregnant women, in order to promote comprehensive and effective care for them and their families. (Kliemann, et al. 2017). Research also reinforces that there are factors related to mental disorders during pregnancy that are associated with the social and family environment, such as, for example, a history of mental illness, high levels of stress and family dynamics. And this demonstrates a need for a multidimensional assessment of the psychosocial conditions of these pregnant women during their prenatal period (Lopes, et. al., 2019).

In the study by Santana (2019), they provide evidence that there are numerous factors that trigger anxiety, such as, for example, precarious economic and social conditions, the use of alcoholic beverages, the age and education of the mother, the habit of smoking, between others. This same study states that anxiety is a possible determinant for prematurity in terms of low birth weight. Therefore, the anxiety factor can negatively affect the gestation period, as there are significant hormonal changes and also risky behaviors, such as poor diet, delay or inadequate prenatal care, for example (Kliemann, 2017). Feelings of fear, anxiety or suffering can happen to pregnant women, especially when they are classified as high risk. Studies show that pregnant women have an exacerbation of anxiety and depressive symptoms during childbirth and the puerperium, with the potential to have a negative impact on the child's health and intra-family relationships (Oliveira, 2011).

In a study carried out by Medeiros (2016), based on the nursing diagnosis, anxiety related to the uncertainty of the evolution of the pregnancy appeared in 77.2% of the pregnant women interviewed. Even knowing that pregnancy is a physiological process, there are factors that trigger situations that can affect the health of the pregnant woman and her child, which can create situations of fear, uncertainty and tension. Thus, the fear related to the end of the pregnancy and the birth itself was reported in the study by Santos & Vivian (2018) where the pregnant women stated that they feared for both maternal and fetal health, especially the fear of the child being born with physical abnormalities and the fear of dying during childbirth. In the present study, the classification of anxiety by the DASS-21 instrument, showed that the results were not significant, however, there is a greater predisposition for anxiety at moderate to extremely severe levels, for pregnant women in the rural area 44.4% than for those from urban area 35.7% (Table 3).

Therefore, anxiety and depression are feelings that can manifest themselves during different stages of life and during pregnancy, as it is a time of intense change. Depression can cause different behavioral or emotional changes in pregnant women, reaching up to 15% of them, if in the puerperium, it is necessary to seek a specific treatment (Fernandes, 2013). Studies show that depression is more susceptible in pregnant and postpartum women, due to the physical, psychological and hormonal changes in this phase (Guimarães, et. al. 2021). In the study by Dagklis (2016) describes in his research that the prevalence rate of symptoms related to depression occurs in pregnant women with high-risk prenatal care than in those pregnant women

who are in low-risk prenatal care. A study carried out in Alfenas, Minas Gerais, with 209 pregnant women, where the Hospital Anxiety and Depression Scale (HADS) was applied, observed that among pregnant women who had depression during pregnancy, the majority (48.4%) were in the second trimester of the pregnancy period, however, in this study, no statistically significant difference was found between risk of depression and the trimester in which the pregnant woman was (Silva, et. al. 2016). In this study, pregnant women in rural and urban areas who responded to the instruments belonged to all pregnancy periods (1st, 2nd and 3rd trimester), and it was observed in the classification of depression by the DASS-21, that there was no significant difference between them, with 88 .9% of pregnant women in rural areas and 85.7% of pregnant women in urban areas with a normal classification for this common mental disorder (Table 3).

In the study by Antoniazzi, et. al. (2019) who evaluated the quality of life through the WHOQOL-BREF in pregnant women, observed that there is a great need for social support with pregnant women, and that the participation of the family and health professionals can provide more peace of mind for the pregnant woman and her baby. child after delivery, improving their quality of life. In the study by Santos, et. al. (2015) in the city of Rio Branco - AC, northern region of Brazil, with 352 pregnant women, it can be observed that when applying the WHOQOL-BREF instrument, the lowest scores were found in the environmental and psychological domains, and that in the physical domain it presented greater difference between age groups. In this study, 73.2% of the pregnant women in the urban area had lower quality of life indices in the psychological domain, which was statistically significant in relation to 83.3% of the pregnant women in the rural area, who had a higher level of quality of life for this period. domain. There was also a significant difference in the social domain, where 68.5% of the pregnant women in the urban area had a lower quality of life score compared to 91.7% of the pregnant women in the rural area (Table 4).

In table 5, based on Pearson's correlation, it was possible to confirm that pregnant women in rural areas had worse quality of life scores in the physical domain (SRQ) and anxiety levels (DASS 21). The WHOQOL BREF in the physical domain analyzes pain and discomfort, energy and fatigue, sleep and rest, mobility, activities of daily living, dependence on medication or treatments and work capacity. So somehow it would be necessary to carry out a work to understand which situations cause greater discomfort.

In addition, in table 5, it was also possible to observe that the Pearson correlation performed between the SRQ instruments and the DASS21, in the psychological domain, in pregnant women in the urban area, presented lower quality of life indices for depression. The psychological domain of the WHOQOL-BREF analyzes positive feelings, thinking, learning, memory and concentration, self-esteem, body image and appearance, negative feelings, spirituality/religion/personal beliefs. It is possible to suggest that pregnant women in urban areas end up having a higher level of demand, which is reflected in their behavior.

In the present study some limitations must be highlighted. The first is the small number of pregnant women evaluated. One factor that made it difficult to expand this sample was due to the COVID-19 pandemic, which directly affected the care of pregnant women, and the low demand. Another important factor is that, due to the smaller sample size, it was not possible to choose pregnant women from a given

trimester to be evaluated; and as described in this article, pregnancy is a process in which numerous changes occur during its course.

4 FINAL CONSIDERATIONS

From this study, it was possible to draw a profile of pregnant women in rural and urban areas who performed prenatal care at the Bela Floresta Health Center, in the municipality of Estância Turística de Ouro Preto do Oeste/RO, Brazil. Regarding the socio-demographic profile, the two populations are very similar in all parameters, in both the average age is very similar, the brown color was evident, with complete secondary education, married or in a stable relationship, living with up to one minimum wage and pregnant women in the urban area are predominant in relation to paid work.

As for the common mental disorder, assessed by the SRQ instrument, it was not possible to detect in this population of pregnant women, and both are within the normality criteria. Likewise in relation to the analysis of the levels of stress, anxiety and depression assessed by the DASS21 instrument, in both populations they are within the standards considered normal. However, when observing the quality of life, it was possible to perceive that in the psychological and social domains, pregnant women in urban areas have lower levels of quality of life, and that pregnant women in rural areas have better levels of quality of life. Therefore, with this study, it is perceived the need to investigate the regionalities and it is perceived that there are positive and negative characteristics in each one, however, by knowing each other better, it is possible to outline more concrete objectives to support pregnant women.

Few articles describe the situation of pregnant women in the northern region of Brazil in relation to their epidemiological profile and demands. Therefore, knowledge of the population of this region is fundamental for the development of public policies. Thus, profiling pregnant women is essential to ensure a healthy pregnancy for both the mother and the newborn. As well as knowing the different realities can indicate ways to promote a better quality of life for pregnant women in their different realities, thus facilitating better actions in promoting the health of this public.

REFERENCES

Antoniazzi, M.P., Siqueira, A.C. & Farias, C.P. (2019). Aspectos Psicológicos de uma gestação de alto risco em primigestas antes e depois do parto. Pensando Famílias, 23(2), 191-207.

Apóstolo, J.L.A., Mendes, A.C. & Azeredo, Z.A. (2006). Adaptação para a língua portuguesa da depression, anxiety and stress scale (DASS) Rev Latino-am Enfermagem, 14(6), 1-9.

Brasil. (2013). Sistema de Informação da Atenção Básica. *Ministério da Saúde.*

Castro, D.F.A. & Fracolli, L.A. (2013). Qualidade de vida e promoção da saúde: em foco as gestantes. O Mundo da Saúde, 37(2), 159-165.

Dagklis, T., Papazisis, G., Tsakiridis, I., Chouliara, F., Mamopoulos, A. & Rousso, D. (2016). Prevalence of antenatal depression and associated factors among pregnant women hospitalized in a high-risk pregnancy unit in Greece. Soc Psychiatry Psychiatr Epidemiol. 51, 1025–1031.

Dias, G.B., Alves, L., Pereira, S.N. & Campos, L.M. (2018). Ações do enfermeiro no pré-natal e a importância atribuída pelas gestantes. Revista SUSTINERE, 6(1), 52-62.

Fernandes, C.F. & Cotrin, J.T.D. (2013). Depressão pós-parto e suas implicações no desenvolvimento infantil. Revista Panorâmica On-Line, 14, 15–34.

Gadelha, I.P., Aquino, P.S., Balsells, M.M.D., Diniz, F.F., Pinheiro, A.K.B., Ribeiro, S.G. & Castro, R.C.M.B. (2020). Qualidade de vida de mulheres com gravidez de alto risco durante o cuidado pré-natal. Rev. Bras. Enferm, 73(5), 1-7.

Gomes, C.B., Vasconcelos, L.G., Cintra, R.M.G.C., Dias, L.C.G.D. & Carvalhaes, M.A.B.L. (2019) Hábitos alimentares das gestantes brasileiras: revisão integrativa da literatura. Ciênc. saúde colet., 24(6), 27.

Guimarães, R.B., Santos, R.B., Santos, T., Carvalho, A.R., Lima, M.A.C., Costa, T.A., Oliveira, H.F., Santos, T.O., Jesus, L.S. & Farah, L.E. (2021). Atuação à gestante e puérpera com depressão. REAS/EJCH, 13(1), 3. https://doi.org/10.25248/reas.e5178.

Hanlon, C., Medhin, G., Alem, A., Araya, M., Abdulahi, A., Hughes, M. (2008). Detecting perinatal common mental disorders in Ethiopia: Validation of the self-reporting questionnaire and Edinburgh Postnatal Depression Scale. J Affect Disord., 108(3), 251-262.

Harding, T.W., Arango, M.V., Baltazar, J., Climent, C.E., Ibrahim, H.H.A., Ignacio, L.L., Murthy, R.S. & Wig, N.N. (1980). Mental Disorders in primary health care: a study of their frequency and diagnosis in four development contries. Psychological Medicine, 10:231-241.

IBGE – Instituto Brasileiro de Geografia e Estatística. Censo Demográfico. 2011.

Kliemann, A., Boing, E. & Crepald, M.A. (2017). Fatores de risco para ansiedade e depressão na gestação: Revisão sistemática de artigos empíricos. Mudanças-Psicologia da Saúde, 25(2), 69-76.

Lopes, R.S., Lucchese, R., Souza, L.M.M., Silva, G.C., Vera, I. & Mendonça, R.S. (2019). O período gestacional e transtornos mentais: evidências epidemiológicas. Rev. Multidisciplinar Humanidades e tecnologias, 19(13), 35-54.

Lucchese, R., Simões, N.D., Monteiro, L.H.B., Vera, I., Fernandes, I.L., Castro, P.A., Silva, G.C., Evangelista, R.A., Bueno, A.A. & Lemos, M.F. (2017). Fatores associados à probabilidade de transtorno mental comum em gestante: estudo transversal. Esc. Anna Nery, 21(3), 1-6.

Lucchese, R., Sousa, K., Bonfin, S.P., Vera, I. & Santana, F.R. (2014). Prevalência de transtorno mental comum na atenção primária. Acta Paul Enferm., 27(3), 200-207.

Medeiros, A.L., Santos, S.R., Cabral, R.W.L., Silva, J.P.G. & Nascimento, N.M. (2016). Avaliando diagnósticos e intervenções de enfermagem no trabalho de parto e na gestação de risco. Rev Gaúcha Enferm, 3(3).1-9.

Naseem, K., Khurshid, S., Khan, S.F., Moeen, A., Farooq, M.U., Bajwa, S., Tariq, N. & Yawar, A. (2011). Health-related quality of life in pregnant women: a comparison between urban and rural populations. JPMA. The Journal of the Pakistan Medical Association, 61 (3), 308-312.

Oliveira, E.C., Barbosa, S.M. & Melo, S.E.P. (2016). A importância do acompanhamento pré-natal realizado por enfermeiros. Revista Científica FacMais, 7(3), 24-38.

Oliveira, V.J., Madeira, A.M.F. & Penna, C.M.M. (2011). Vivenciando a gravidez de alto risco entre a luz e a escuridão. Rev. Rene, 12(1), 49-56.

Pio, D.A.M. & Capel, M.D.S. (2015). Os significados do cuidado na gestação. Rev. Psicol. Saúde, 7(1), 74-81.

Santana, M.L.S. (2019). Saúde Mental: Teoria e Intervenção. Atena Editora.

Santos, A.B., Santos, K.E.P., Monteiro, G.T.R., Prado, P.R. & Amaral, T.L.M. (2015). Autoestima e qualidade de vida de uma série de gestantes atendidas em rede pública de saúde. Cogitare Enferm., 20(2), 392-400.

Santos, C.F. & Vivian, A.G. (2018). Apego materno-fetal no contexto da gestação de alto risco: contribuições de um grupo interdisciplinar. Diaphora, 18 (2), 9-18.

Santos, K.O.B., Araújo, T.M., Pinho, P.S. & Silva, A.C.C. (2010). Avaliação de um instrumento de Mensuração de morbidade psíquica: estudo de validação do self-reporting questionnaire (SRQ-20).Revista Baiana de Saúde Pública, 34(3), 544-560.

Silva, M.M.J., Leite, E.P.R.C., Nogueira, D.A. & Clapis, M.J. (2016). Depressão na gravidez. Prevalência e fatores associados. Invest. Educ. Enferm, 34(2), 342-350.