RESEARCH

DIMENSIONS OF MATERNAL HEALTH FROM THE PERSPECTIVE OF SOCIAL REPRESENTATIONS

DIMENSÕES DA SAÚDE MATERNA NA PERSPECTIVA DAS REPRESENTAÇÕES SOCIAIS

DIMENSIONES DE LA SALUD MATERNA DESDE LA PERSPECTIVA DE LAS REPRESENTACIONES SOCIALES

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ABSTRACT

An integrative literature review was conducted to identify the trends in maternal health from the perspective of social representations. The search occurred within the LILACS, BDENF, SCIELO databases, between the years 2003-2011, with 15 articles selected. After the thematic analyses of the contents of the articles, two dimensions were obtained: sociomaternal dimension and the socio-caring dimension. The sociomaternal dimension considered the social representations of women about pregnancy, prenatal care, normal and cesarean delivery, breastfeeding, and rooming-in. The outcomes revealed the necessity of exploring women's common sense and to integrate them into the scientific approach so that they developed autonomously the care for themselves as well as for their baby. The evidence showed a need for professionals to rethink verbal and non-verbal communication, observing more humane and nurturing attitudes. The socio-caring dimension integrated the social representations about the health care during the prenatal period in nursing consultation; nursing care in the puerperium; nursing care in the puerperal gestational cycle among women, and childbirth care; health care in the Family Health Strategy; integrality and teamwork among professionals. In conclusion, the necessity of broadening the vision of health professionals beyond the biomedical and techno-scientific approach is essential in order to incorporate health education in health and a biosocial-humanistic approach.

Keywords: Labor, Obstetric; Prenatal Care; Women's Health.

RESUMO

Foi realizada revisão integrativa de literatura com vistas a identificar as tendências em saúde materna na perspectiva das representações sociais. A busca ocorreu nas bases LILACS, BDENF, SCIELO, entre 2003-2011, com seleção de 15 produções. Após análise temática de conteúdo das produções, obtiveram-se duas dimensões: a sociomaterna e a sociocuidativa. A dimensão sociomaterna considerou as representações sociais das mulheres sobre gestação, pré-natal, parto normal e cesáreo, amamentação e alojamento conjunto. Os resultados revelaram a necessidade de se explorar o senso comum das mulheres e integrá-los ao científico para que elas desenvolvam com autonomia o cuidado de si e do bebê. As evidências demonstraram que há necessidade de os profissionais repensarem a comunicação verbal e não verbal, vislumbrando atitudes mais humanas e acolhedoras. A dimensão sociocuidativa integrou as representações sociais sobre o cuidado em saúde no pré-natal na consulta de Enfermagem; cuidado de Enfermagem no puerpério; cuidado em Enfermagem, no ciclo gravídico puerperal entre mulheres e assistência ao parto; cuidado em saúde na ESF; integralidade e trabalho em equipe entre profissionais. Concluiu-se pela necessidade de se ampliar a visão dos profissionais de saúde para além da biomédica e técnico-científica, com vistas a incorporar a educação em saúde e uma visão biossócio-humanista.

Palavras-chave: *Trabalho de Parto; Cuidado Pré-Natal; Saúde da Mulher.*

RESUMEN

Se llevó a cabo una revisión integradora de la literatura con miras a identificar las tendencias en salud materna desde la perspectiva de las representaciones sociales. La búsqueda se realizó en las bases de datos LILACS, SCIELO BDENF entre 2003-2011; se seleccionaron 15 producciones. Después del análisis del contenido de las producciones se obtuvieron dos dimensiones: la socio-materna y la socio-cuidativa. La dimensión socio-materna consideró las representaciones sociales de las mujeres sobre el embarazo, atención prenatal, parto normal y parto por cesárea, lactancia materna y alojamiento conjunto. Los resultados revelaron la necesidad de explorar el sentido común de las mujeres e integrarlo al científico para que desarrollen con autonomía su propio cuidado y el del bebé. La evidencia demostró que los profesionales deben repensar la comunicación verbal y no verbal, previendo actitudes más humanas y acogedoras. La dimensión socio-cuidativa integró las representaciones sociales sobre el cuidado en salud en la atención prenatal de la consulta de enfermería; atención de enfermería en el post-parto, atención de enfermería durante el embarazo y el parto, atención de la salud en el ESF, integralidad y trabajo en equipo entre los profesionales. Se llega a la conclusión que es necesario ampliar la visión de los profesionales de salud, más allá de la biomédica y técnico-científica, con miras a incorporar la educación para la salud y una visión bio-sociohumanística.

Palabras clave: *Trabajo de Parto; Atención Prenatal; Salud de la Mujer.*

INTRODUCTION

The area of women's health has gained space in public policy and obtained advances in studies and actions for the reduction of maternal and infant mortality. However, despite this reduction, the indicators are still far from the target set for 2015, within the Millennium Development Goals, which is a maximum of 35 maternal deaths per 100,000 live births.[1]

The Ministry of Health states that pregnancy, delivery and the postpartum period constitute one of the most significant of human experiences, with strong positive and enriching potential for those who participate in it. Health professionals are adjuvants of this experience and play an important role. They have the opportunity to use their knowledge to serve the well-being of the woman and of the baby, by recognizing the critical moments in which their interventions are necessary to ensure their health.[2]

Pregnancy, birth and postpartum are, therefore, conceived as exceptional moments in the life of the woman, due to their specific characteristics, related to cultural, social, economic and biologic aspects. The need of the biosychosocial adaptation of pregnancy; the learning situations involving the care of the mother and baby; the interpersonal relationships with health professionals; the incurred influences of the media and of shared and lived experiences indicate that social representations are produced in these spaces of care-caring, in which individual and collective thoughts intertwine.

From this perspective, social representations (SR) can influence the behavior of the individual participant of a collective. In this manner, the collective itself permeates as a determining factor, within individual thought.[3] The affirmation of the author leads to an understanding that the social representation can be reconsidered or re-signified, allowing new knowledge and social practices.

As worldwide systems of shared understanding, the social representations provide standards of knowledge, guidelines and conduct that transform social environments in homes for the individual actors. Solidified in cultural and institutional practices, they provide the resources for the construction of social identities and for the renovation of societies.[3]

The high rates of maternal and infant mortality related to the low quality of obstetric and prenatal care, and family planning, leads to thoughts about the lack of effectiveness of programs and technical manuals designed for maternal health care, which aim to guide professional actions. However, those actions of the professionals are guided by their own representations about the phenomena. In contrast, these professionals ignore the necessity of guided actions, considering that these attitudes are driven by their representations.

In order to identify the trends of the research about maternal health from the perspective of social representations, seeking to promote reflections that support new studies and enable the development of new thinking and acting for maternal health care, this literature review was conducted.

Studies that had an objective of understanding the social representations about phenomena inherent to maternal health were selected. It was understood to be interesting to include, among the studies with women, those conducted with professionals who worked in the area of women's health, by the possibility of making correlations between common and scientific sense and to understand how such conduct is guided by social representations.

METHODS

An integrative review of the literature was conducted according to the six proposed methodological steps.[4] The first step was the selection of the topic (maternal health) and the research question: what are the social representations of women and professionals about the maternal phenomena and care that are manifested in the puerperal gestational cycle and in women's health care.

In the second step, the following inclusion criteria were defined: studies in the form of an article, about maternal health, during the period of 2003-2011, from the perspective of social representations, both of a structural and procedural approach; in Portuguese or Spanish language; with a title and abstract available and indexed in the databases; published in national and international journals.

After defining the inclusion criteria, a literature search was developed by means of searching in databases available through Internet: Literature of Latin America and the Caribbean (LILACS), Database of Nursing (BDENF) and *Scientific Electronic Library on Line* (SciELO).

In order to search for the research articles, five standardized health sciences descriptors were used: labor and delivery; prenatal care, women's health, family health, and, breastfeeding. In order to limit the search, four keywords not included in the standardized health science descriptors were used: social representation, social representations, social behavior, and, social psychology.

Through a combination of the descriptors *labor and delivery* and *women's health*, 487 publications were found; 555 studies were detected using the descriptors *prenatal care* and *family health*; with the descriptors *breastfeeding* and *women's health*, 342 citations were selected, leading to a total of 1,384 studies. By using those keywords in each block of publications, only 15 articles were found.

In the third step, the selected references were cataloged according to the production profile, allowing the organization of information such as: title, objectives, descriptors, year, location, number of authors, modality, publication type, approach, subjects, data collection technique, and results in evidence.

The fourth step consisted of thematic analysis of the studies, through observations of methodological aspects, the familiarity between the subjects, and the results encountered. In the fifth step, the evidence was categorized and grouped, revealing the following dimensions:

a. **socio-maternal dimension:** the social representations of women about the puerperal gestational cycle; prenatal – normal and caesarean delivery; breastfeeding; rooming in, with eight studies grouped in this dimension;
b. **socio-caring dimension:** social representations of women about prenatal healthcare in the nursing consultation; postpartum nursing care; care in pregnancy and childbirth, and social representations of women and professionals about childbirth care; health care in the Family Health Service (FHS); comprehensiveness and teamwork. Seven studies were grouped in this dimension, totaling 15 articles.

In the sixth step of the discussion and interpretation of results, considerations and recommendations for the care practices in maternal health were developed, as well as suggestions for research.

RESULTS AND DISCUSSION

There are still very few scientific publications in maternal health from the perspective of social representations, since only 15 studies were encountered from the total universe of 1,384 productions in the area. The selected studies, in the majority, prioritized the phenomena of social representations among women, with a deficit of publications of the phenomena about social representations among professionals, among which three studies were encountered.

It was ascertained that only a few studies crossed, with research of the same phenomenon among different subjects, women and professionals in the area, since only one study was obtained. After bringing together the characteristics of the sample studied, this resulted in the participation of 464 subjects between women and healthcare professionals.

In the field of social representations, the most utilized approach was procedural, demonstrating that the structural approach may be more widespread and used. The technique of data collection that occurred most frequently was the semistructured interview, while few used the Technique of Free Word Association (TFWA). In the data analysis, the major option was for content analysis of the categorical thematic type. As for the phenomena of maternal health, it was perceived that childbirth was the highest choice. It also emphasized the increasing production in the nursing area of studies on maternal health from the perspective of social representations.

The analyzed data revealed the production of knowledge that in its results presented positive, negative and general aspects with respect to the phenomena that, for methodological reasons, allowed the characterization and grouping in dimensions.

SOCIO-MATERNAL DIMENSION

In this dimension, the social representations of women about pregnancy; prenatal, normal and cesarean delivery; breastfeeding; and, rooming in were considered. From the perspective of the women, the social representation about pregnancy is understood as a complex and unique phenomenon, which involves several biological, physiological, psychological, social and cultural changes. The expression of being pregnant means to give visibility to femininity and to reaffirm fertility as something that elevates womanhood.[5]

In this sense, it is understood that, for the women surveyed, pregnancy is represented as a phenomenon that extends beyond the reproductive function, consisting of: psychosocial, cultural, biological, educational and humanistic dimensions. The comprehensiveness of the term pregnancy can be seen, by the evidence, to lead to the need for care that considers the constituted dimensions, which should occur in a holistic form.

In accordance with the way in which women represented pregnancy and the need for prenatal care to come to this encounter, we saw the relevance of understanding the social representations about the prenatal period among women, considering that it is from everyday interactions by means of dialogical action that communication occurs, and in this, social representations emerge. In this sense, there was inefficiency noted in the process of communication between mothers and professionals from pre-natal care; and the welcoming was not viewed as effective by the group of pregnant women.[6] Communication between mothers and professionals involved in prenatal care showed itself to be positive in the satisfaction of pregnant women in some areas, but this added to concepts of underexplored common sense by the prenatal care teams.[7]

There was evidence of the passive position of women, which determined the autonomy and the power of health professionals in prenatal health care, allowing space for development of new studies that provide for the listening and valuing of women's knowledge, envisioning the constitution of a knowledge derived from the interaction between the ordinary and scientific universes. In this manner, the professional as a mediator in the process could empower the woman to assume her leading role.

During pregnancy and in the period of prenatal care, it was assumed that childbirth was the most anticipated moment, one of more expectations and fears. In this manner, the importance of understanding the social representations of normal and cesarean delivery among women was conceived.

From this perspective, the experience of previous labor and delivery proved to be a strong element that influenced the current decision about the mode of delivery.[8] The social representations of normal childbirth were of an active birth, in which the pain was experienced as the "mother's pain".[9] Such thinking led to a bearable and natural pain for all woman.

The social representation of women about birth was replete with fundamental anchors based on natural suffering at the hour of birth. The technical procedures such as consultations, examinations and educational activities were discussed and valued in the expectation of good health for the child.[9] This demonstrates the dominant paradigm that dates back to the first actions in maternal health, whose focus was the birth and the growth of healthy children.

In another study, the moment of birth led to a moment of pain. Fear of pain was strongly represented in the imagination of pregnant women, and transformed with the proximity of delivery, in the genesis of other fears: fear of labor; fear of performance and of commitment and of fetal well-being; fear of anesthesia; fear of the unknown, among others.[10] The positive, negative and general aspects about normal and caesarean delivery revealed themselves as the leading role of women; better recovery from normal birth, the absence of pain in cesarean delivery; and, dissatisfaction with the care received.[9]

If the delivery was adequately explained and discussed with women since the first prenatal consultation, probably the fear, influenced by the media or by conversations between women or also personal and family histories, would be attenuated, considering the transformation of an unfamiliar to the familiar situation.

Childbirth involves an individual issue and is related to the women's ability to cope with pain during labor and delivery. The other issue is the relationship between the woman and the health care professional in the hospital context, where most of the deliveries occur. This relationship directly influences the performance and the empowerment of women, or the lack thereof, to the measure that the professionals take the position of coadjuvant in the framework of labor and birth. In this sense, the event of labor and delivery, for women, indicated how the experience of hospitalization was still seen in their eyes as a threat to feminine dignity.[11] It was in the emphasis on the relationship between the woman and the professional that assisted in the delivery, the evidence of these interactions during childbirth were revealed.

The importance of communication and interpersonal relationship between the professional and the clients must be emphasized.[6] There was little dialogue between the pregnant woman and the physician on issues related to the time of delivery.[7] Other evidence showed a lack of fundamental information of all women attended in the public and private sector to experience the delivery safely and with self-determination.[9] There were contradictions in the relationship of the healthcare professional and users mediated by questions of gender present at time of delivery and by the nature of services. Women presented some criticisms of what was done to them.[9]

With respect to delivery, a need for further clarification for the women was noted, since it was a very feared moment, and one that might be associated with death and other complications, so there was the need to prepare, in which the technical procedures, emotional and cultural aspects might be considered. These data demonstrated the need for health education in the pre-natal period about labor and childbirth.

In the present day, in which the practice of cesarean birth seems to be a routine act, both in public service and in private care, and in both socioeconomic groups of women, many advantages to natural childbirth have been highlighted, considering: the experience of the leading role and more satisfaction in the birthing scenario; the differences in medical care; the quality of the relationship with the baby; and the postpartum recovery.[9]

However, the rationale for the increase in cesarean section procedures corresponded to the fear of the pain of delivery, and ignorance of the benefits of natural childbirth. Some women in the private sector highlighted the possibility of scheduled delivery due to the hectic lifestyle of the contemporary woman. However, the main reason highlighted for the increase in cesarean rates was the convenience of the physician, because it was a much faster procedure.[9]

Another study reaffirmed this statement. Pain revealed itself as one of the leading constructs of current female representations about childbirth and contributed to the increased numbers of cesarean sections in Brazil. Pain was observed to influence the behavior of pregnant women because of fear, and it became the genesis of other aversive feelings and concerns surrounding the event of delivery.[8] A lack of knowledge of the women about the benefits of natural birth and the risks of cesarean section was observed.

These results indicated a different behavior between the public and private sectors, considering that the woman in the public service had no option of choice and caesarean section should only be performed due to an obstetrical indication. In both the public and the private sector, there was a lack of information observed for women about vaginal delivery and cesarean section. The social representation of childbirth, guided by the suffering of pain, was influenced by the media when audiences were frightened with scenes of childbirth, discouraging women, yet valuing other types of pain, such as with fighters and athletes. In contrast, the cesarean section is trivialized, considered as an invasive procedure for women and the trauma of mechanical extraction of the fetus. From this perspective, there is a manipulation of information according to different interests, demonstra-

ting the taking of power by means of scientific knowledge, which often excludes the woman's role at the time of childbirth.

After the childbirth and expulsion of the placenta, the woman enters the puerperal period, characterized by physiological and emotional changes. After delivery, women receiving care in a public service are forwarded to the *rooming in* location, where they remain with their baby for adaptation, breastfeeding and care. This is followed by the phenomenon of breastfeeding.

One of the great anxieties and challenges of women related to the care of the baby is that of breastfeeding. The structure of the social representation about breastfeeding showed a high frequency of pleasure, love and affection categories, revealing the importance of breastfeeding and of human milk. The health of the baby was expressed more in the group of non-working mothers, suggesting that these women anchored breastfeeding in the process of health-illness .[12]

In another study, breastfeeding was treated as a natural attribute, in which the social role of the woman was that of the nursing mother. Pregnant women represented breast milk as a nutrient that contributed to the growth and development of the baby.[5]

In representations submitted about breastfeeding, there was an understanding that breast milk conferred other advantages that benefitted the mother, such as: a more rapid decrease in uterine volume; prevention of postpartum hemorrhage; protection against anemia; as well as an association with the reduced risk of breast cancer .[5]

The women recognized the value of breastfeeding and of the qualities of human milk. The same recognition was not given to the exclusivity factor, nor to the time required for exclusive breastfeeding.[12] This question determined the need for health education about exclusive breastfeeding in the first months of life of the newborn. Considering that breastfeeding occurred primarily in the *rooming in* environment, the location for recovery, care and learning of the mother about caring for herself and her baby, the understanding of the social representations about *rooming in* were important.

It was conceived that the social representation about the *rooming in* had as a representational element the hospitalization itself, and it revealed the experience of a place of abandonment where they were subjected to procedures, and that it was the domain of professionals.[11] The values that women attributed to the interpersonal interactions suggested that interpersonal relationships were real tools that helped women pass through the experience of hospitalization.[11]

The puerperal woman represented the need to redirect the attention of nursing professionals in caring for herself and her child in a way that it became suitable for the performance of motherhood.[13] This accentuated the need for guiding the relationships between women and professionals beyond the biological dimension, to consider the psychosocial aspects and make the practice of health education continuous in the *rooming in* environment, along with actions guided by the needs represented by the women. Considering the action of nursing professionals both in primary and in secondary care, it is relevant to list the social representations about nursing care and nursing consultation.

SOCIO-CARING DIMENSION

This dimension included the social representations of women about healthcare in prenatal nursing consultation; postpartum nursing care; health care in pregnancy and childbirth; and social representations among women and professionals about childbirth care; health care in the FHS, comprehensiveness and teamwork.

The social representations about health care during the prenatal period emerged positively from the statements of the mothers, related to the interaction between professionals and users characterized by listening, attention and cordiality, and related to the availability of exams, promptness in service and in developing basic actions.[13]

The social representations about health care at the moment of delivery, for puerperas, were subdivided into four themes: the welcoming of the laboring women, the support given to women during childbirth, the woman as the protagonist in the process of care during delivery, and the technical quality of care.[13]

The social representation about childbirth care had positive aspects and highlighted the elements: to be well cared for, to receive attention, affection, to be treated well, prompt service, to have the professional at the bedside, treatment as an equal, holding of one's hand, welcoming by the health team, and psychological support.[14] The social representations about delivery care among women receiving care consisted of the quality of the relationship established with the professionals as the factor that most influenced the manner in which they represented the care received.[15] The mothers praised the care according to relational support and humanistic values; and elements seen as not caring were identified as negative aspects, showing the need for change in the posture and attitude of some professionals.[7]

Two distinct social representations about care delivery between professionals were suggested: the first denoted a medicalized vision of caring and the other indicated care identified with the proposal of the movement for humanization of labor and delivery. The professionals highlighted an important aspect of care: the presence of the partner, the concern with his humanization, the participation of the obstetric nurse, and the physical space.[15]

The results showed different representations among professionals because they identified a medicalized vision and by

the proposal of humanization, providing research opportunities for understanding how these professionals represented the humanization of childbirth. There recommendations were corroborated and affirmed, that the guidelines of the Program for the Humanization of Childbirth (PHPN) should be incorporated more widely in health practice aimed at women.[16]

According to the analysis of the evidence, we can infer that when professionals represented the humanization of care in childbirth, they also thought about the quality of relationships with the women, a very important aspect to them, being possibly related to the representations. As for the humanization of childbirth, it is emphasized that childbirth care remained subjugated by who is to be the subject of the care, and reproducing the project of medicalization, even if this process manifested itself in different ways among groups of women treated in public service and in private.[7] These results allowed us to consider that the moment of delivery can be characterized as being highly medicalized, very much attached to routines and resistant to humanization.

As for quality of services and humanization of care, the organizational models of public and private services showed variations that produced different types of care and relationship between healthcare professionals and users, shaping distinct experiences among the women surveyed.[7]

This led us to reflect about care as a right and exercise of women's citizenship, regardless of the models of care, whether it is public or private. This fact suggested the rethinking of the practice of some professionals and the routines of certain services.

In the social representations about health care in the postpartum period, a single theme was highlighted: supporting the development of the mother-infant relationship. It may be considered that in the prenatal and postpartum periods, the care is not without problems, since the women are generally treated as coadjuncts in a care process often marked by the absence of attachment with the professionals.[16] This evidence referred to actions based on physical complaints, emphasizing the biomedical and technical role that valued the leading role of the professional rather than of the woman, the subject of care.

The Family Health System program is a strategy of Primary Health Care, which seeks to strengthen actions for prevention and health promotion, among which prenatal care is identified. This perspective reveals the importance of identifying the social representations of the healthcare teams among the FHS teams.

It could be seen that FHS health professionals shared a common representation, whose central core was composed of semantic aspects such as welcoming, attention and love. The subjects presented different understandings about the process of care in the FHS. The constructed knowledge with respect to this issue was supported through a vision approximating the meaning of care.[17]

However, this understanding had elements related to biomedical, technical and scientific aspects. Care was not incorporated as a key element of the work process within the FHS.[17] It is believed that the statement of the authors revealed the ambiguity of the term, health care, guided by concrete and subjective actions inherent in such practices.

In the social representations of women about nursing care, the following categories emerged: satisfaction and dissatisfaction with care. Satisfaction with care was confirmed by the fact that the nursing staff was interested in their health status, promptly meeting their biological needs, and being available for support. Dissatisfaction with nursing care presented in the postpartum period, with more disappointment than in the pre-natal and delivery periods.[17]

This fact demonstrated that nursing care was still considered from the perspective of the act as intervention, and of promptness and cordiality, however, revealing the need to extend these primary concepts during the postpartum phase.

The large majority of pregnant women expressed positive representations about nursing consults during prenatal care, mostly due to the form in which relationships were established between the nurse and the pregnant women, in which welcoming and listening were favored.[5]

The pregnant women reported familiarity with nursing consultation during the prenatal period. Therefore, they initially had the perception that it was a procedure complementary to the work of the physician.[5] This emphasized the need for dissemination of nursing consults as actions independent of the medical professional, and as a space for health promotion and disease prevention. Considering the quality of care with a view toward comprehensive action and teamwork, the need to understand the social representations of nursing professionals with regard to comprehensiveness and teamwork was identified.

Regarding the integrated vision of care for women's health, it was verified that the nurse had a fragmented vision of care, still guided by physical complaints. She could not define what comprehensiveness was, repeating the discourse of holistic care, without understanding what it really signified. She worked individually, understanding that the service was not structured to offer comprehensive care. This fragmentation appeared in all axes of the analysis, and was implicit in health care not only of women, but of all patients seen in the primary network.[18]

As regarded teamwork, the nurse who worked in women's health care said that she worked in a team, but perceived that all professionals did not have the same objective and worked in an individualized manner. Although there was perceived to be a link between professionals and clients, the feeling existed that there was a struggle for space and power among the professionals.[19]

These issues showed that both interdisciplinarity as well as transdisciplinarity are far from reality in healthcare services,

which compromised the comprehensive assistance to clients, demonstrating the need for educational institutions to prepare professionals to work in teams and for institutions to invest in their health professionals through the development of teamwork in the context of lifelong learning.

CONSIDERATIONS AND TEMPORARY RECOMMENDATIONS

Based on the results of this integrative review, it was possible to respond to the research question, which led to reflections and recommendations. The social representations about pregnancy were strongly related to the act of sublime and divine motherhood, which corresponded to a natural and emotional phenomenon. Social representations about the prenatal period, normal and cesarean delivery, and breastfeeding, were subsidized through the daily experiences of women with the health services, in the relationship with professionals, and in informal conversations, also receiving media and family influences.

These issues in our understanding were reflected in the passive action of the woman in the difficulties to care for herself and her child with autonomy, which reaffirmed the empowerment of professionals in the area. For the development of proper knowledge, the woman needs to have her doubts clarified, the myths broken, and prior knowledge valued by negotiation and development of new knowledge and practices. The effectiveness of such conduct between women and professionals depends on communication and interpersonal relationship.

The evidence led us to think that the professional needed to review strategies for verbal and non-verbal communication that are viewed as more humane and welcoming attitudes. There was a need to open a channel for dialogue, in which the listening and speaking were integrated into the construction of the interactions and mutual respect.

By analyzing the trends contained in both dimensions, it is clear that, although some professionals were worried about the humanization of care, indicating an action guided by a socio-humanistic paradigm, the biomedical and technical-scientific paradigm was predominant in guiding actions throughout pregnancy and childbirth. Social representations about the pre-natal peirod, labor and delivery care, health care, breastfeeding, and *rooming in* were guided by the biological and interventionist actions of care.

These representations were related, in our view, to the manner of thinking and acting of the professionals, showing that they were guided by a bio-technical paradigm of care that occurs in pregnancy and childbirth. There is a need to change this dominant paradigm, so that both women and professionals resignify their knowledge and practices and produce new social representations that may contribute to the transformations in the current scenario.

This integrative review reaffirmed the importance of prenatal care as a process of prevention and promotion of women's health, due to the relationship of quality of prenatal care with maternal and neonatal mortality. It is noteworthy that the prenatal period is a unique moment for health education, in order to develop the knowledge and autonomy of the woman to take care of herself and her baby during pregnancy and childbirth, according to the described needs. On the other hand, it demonstrated the need for continuing professional education, as a vehicle for knowledge, empowerment and the autonomy of women.

As an analysis of the results of this study, the need to rethink public policy for women's health care is suggested, since the described objectives of the manuals of humanized prenatal and delivery are not effectively occurring. Regarding the management of health services, primary and tertiary care have to be strengthened, along with the stimulation of professionals to work in teams, and comprehensive care with a view toward improving actions in health and nursing in maternal health.

It is recommended to reconsider communication, interpersonal relationship and educational process in effect throughout the pregnancy and delivery cycle, especially in the methodologies used in the actions of health education in the prenatal period. It must be disseminated that the nursing consultation is a space for care, promotion and prevention in health care, independent of the medical consultation, and obstetrical nurses should be encouraged to act in the pregnancy and delivery cycle.

Regarding professional education and knowledge production, the mission of higher education that is increasingly developing the vision of future professionals beyond the dominant paradigm must be reinforced. In the research area, studies focused on maternal health from the perspective of social representations, having as their subjects the women, families and healthcare professionals, are recommended.

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