ISSN 2526-8910
Cad. Bras. Ter. Ocup., São Carlos, v. 26, n. 4, p. 768-783, 2018
https://doi.org/10.4322/2526-8910.ctoAO1173

Original Article

Corporality of pregnant women and occupational therapy: possible actions in the Primary Health Care

Sabrina Helena Ferigato[a], Carla Regina Silva[a], Leticia Ambrosio[b]

[a]Departamento de Terapia Ocupacional, Universidade Federal de São Carlos – UFSCar, São Carlos, SP, Brasil.
[b]Universidade Federal de São Carlos – UFSCar, São Carlos, SP, Brasil.

Abstract: Introduction: This paper presents the results of a qualitative intervention research, whose *objective* was to describe and analyze the corporeality of a group of pregnant women and to propose occupational therapy practices in Primary Health Care. Method: Data were produced from the triangulation of different techniques, collective dynamics, body mapping, photovoice, image records and the field diary practice. The field investigated was the Primary Health Care, since it is a privileged space for the meeting of health professionals and pregnant women. Results: It was possible to identify common and singular elements of the feminine corporeity in the gestation process, described in three selected axes: sexuality, the desire to be a mother, materiality and the everyday life in the gestational period. Conclusion: From the analysis of these results, occupational therapy practices were proposed in the sense of meaningful elaboration of corporality and everyday life of pregnant women. Practices with emphasis on the expression of sensitivities and accomplish of women's emancipation, autonomy and protagonism.

Keywords: *Occupational Therapy, Women's Health, Primary Health Care, Pregnancy, Human Body.*

A corporeidade de mulheres gestantes e a terapia ocupacional: ações possíveis na Atenção Básica em Saúde

Resumo: Introdução: Este trabalho apresenta os resultados de uma investigação qualitativa do tipo pesquisa- intervenção, cujo objetivo foi descrever e analisar a corporeidade de um grupo de gestantes e, a partir dessa análise, construir proposições para a intervenção da terapia ocupacional no cuidado em saúde. Método: Os dados foram produzidos com a triangulação de diferentes técnicas: dinâmica grupal, mapa corporal, *photovoice*, registros imagéticos e prática diarística. O campo investigado foi a Atenção Básica à Saúde, por ser um espaço privilegiado de encontro entre profissionais da saúde e gestantes. Resultados: Foi possível identificar elementos comuns e singulares da corporeidade feminina no processo da gestação, descritos em eixos selecionados: a sexualidade, o desejo em ser mãe, a materialidade e o cotidiano no período gestacional. Conclusão: Segundo a análise desses resultados, as intervenções terapêuticas ocupacionais foram propostas no sentido da construção significativa da corporeidade e do cotidiano das mulheres gestantes, com ênfase na expressão de um regime de sensibilidades e da produção de emancipação, autonomia e protagonismo das mulheres.

Palavras-chave: *Terapia Ocupacional, Saúde da Mulher, Atenção Básica à Saúde, Gestação, Corpo Humano.*

Corresponding author: Carla Regina Silva, Departamento de Terapia Ocupacional, Universidade Federal de São Carlos – UFSCar, Rodovia Washington Luís, Km 235, CEP 13565-905, São Carlos, SP, Brasil, e-mail: carla.metuia@gmail.com

Received on June 6, 2017; 1st Revision on Jan. 9, 2018; 2nd Revision on Mar. 7, 2018; Accepted on May 20, 2018.

> Every new body is a new individual in the world (ALMEIDA, 2004, p. 8).

1 Introduction

This study is the result of a qualitative research process of the intervention type, whose focus was the corporeity of pregnant women, according to the occupational therapy in the field of Primary Health Care. We start from the diversity of the processes of gestation and a complex experience that involves different aspects of everyday life in sociocultural processes that result from individual and collective constructions.

Gestation is understood as an exclusive condition for gendered women[1] and it will be treated as a "gender issue". Gender is understood as

> a constituent element of social relationships based on perceived differences between the sexes and as a primary form of giving meaning to power relationships (SCOTT, 1995, p. 86).

Although it can produce singular senses, gestating and raising a child is always a highlight in women's lives. It is a process that generates bodily, psychic and occupational changes and it usually requires affective, social, family, economic and structural adaptation, receiving interferences of the socially predefined definitions of gender, either in the individual or in the collective scope (SILVA; SILVA, 2009).

Thus, pregnancy and motherhood is an experience that is at once corporal, cultural and social, and it is necessary to analyze them within existential contexts, notions of body, gender relationships and other areas that may affect the process of gestation that each pregnant woman lives in a singular way, especially if we consider the body as a cultural territory specific to each woman (DUARTE; LEAL, 1998).

Merleau-Ponty (1994) use the term corporeity to refer to the zone of events and perceptions with the body as its territory of existence. For the author, we would not recognize space or time if we did not have the body, because in this matter, the "trigger point of explanations" is found (MERLEAU-PONTY, 1994, p. 580). It is also with the body that we communicate and put into relationships with others and with the world and we produce our own existence (MERLEAU PONTY, 1994).

> Corporeity would be to think of this body in time, formed by the historical, cultural inscriptions, by the lived experiences. The body is not an organism, a physiology, but something that never ends its structuring. Everything takes place in it: subjectivity, culture, society, powers, oppression, and desires, etc. Each structure of the body results in a material, psychological, social, complex, interconnected, inseparable reality (ALMEIDA, 2004, p. 10).

In this sense, corporeity is understood as an appropriate concept to approach the processes related to the woman's gestation, given the possibilities of transformations, their powers, and their associated limits.

Almeida (2004) affirms that the concept of corporeity contemporaneously crosses the act of doing and occupational therapy, since all action, all experience and occupation operate new structures in the body. In this way, we begin to think about the body and its actions in a complex way, considering the body and the doing articulated in networks, no longer to correct nor to normalize, but to produce new bodies and new actions in the different daily life.

Because we understand everyday life as a central object for occupational therapy, these variations constitute an object of investigation and possible intervention for occupational therapists, professionals who work within the scope of human activities, in all their diversity and uniqueness, including the potential transforming and producing new subjectivities of human doing (MEDEIROS, 2010).

The increasing insertion in the scope of Primary Care to Health is possible to highlight among the many fields of action possible for occupational therapy, a scenario of attention of the Unified Health System (SUS), where the pregnant women are monitored longitudinally in the prenatal and postpartum.

With the expansion of the insertion of occupational therapists in Primary Care, mainly through the Family Health Support Center (NASF), the meeting of this population with this professional nucleus was potentiated in the depth of interdisciplinary interventions and in the actions of matrix support, with the purpose of ensuring specialized rearguard and integral care of the families, as foreseen by SUS guidelines (BRASIL, 2009).

2 Occupational Healthcare of Pregnant Women and the Performance of Occupational Therapy

The relationship established between pregnant women and the health sector has its own historicity and it was fundamental for the conceptual and perceptive construction of pregnant corporality in

the contemporary. Thus, in the cut of this article, this was not the object, so we present some synthetic highlights, especially with the advent of obstetrics as a field of specialties.

With the beginning of obstetrics, in the nineteenth century, a process of increasing centrality of health discourse in the regime of discursive constructions on gestation and childbirth is evidenced. There was also the growing movement of the medical clinic for the development of strategies and techniques of care to prevent risks and aggravations of gestation, associated to the control over the body of the woman through clinical technologies, surgical and medication methods (MATOS, 2003).

These procedures were built within the reference of a hegemonically hygienist, Christian, sanitary and hospital-centered culture, which considers the biological and social roles of women to be mother and child rearing (MATOS, 2003), while at the same time she performs the process of gestation, childbirth and the puerperium, making these moments essential to human life objects of medical power and knowledge (GONÇALVES et al., 2014).

Add to this the preponderant cultural context throughout the nineteenth century, there are the transformations in the body of women from adolescence were classified as transformations for reproduction, condition that every woman would be predestined and that would differentiate her from men (MATOS, 2003).

This context justifies the development of the Public Policies of Women's Health that for decades, reduced women to their reproductive function and health care with strategies aimed only at gynecological and obstetric actions, disregarding other health needs, including sexuality and female pleasures, as well as any form of expression during gestation and delivery (MATOS, 2003). Also, a set of restrictions and deprivations of activities prescribed by health professionals and other sectors of civil society has been imposed on the pregnant body.

On the other hand, since the First Feminist Wave, which took place in the late nineteenth and early twentieth centuries, the feminist movement was consolidated around the struggle for equal rights between men and women and the activism of this period was recognized by the campaigns and achievements of political, sexual, economic and reproductive rights (CRUZ, 2014).

Around 1920, the organized formation of international feminist collectives to fight for reproductive and sexual emancipation introduces variations on statements and practices regarding gestation and socially constructs differences in how to perceive, experience and articulate the corporeality of women, including in the context of health policies.

In Brazil, during the first decades of the 20th Century, health actions for women were directly associated with pregnancy and childbirth in a biomedical model. Only in the 1970s, maternal and child care programs were implemented, but they still included women in the social role of domestic and mother and the pregnant woman as an object of medical intervention (BRASIL, 2004).

In the mid-1980s, the feminist movement and the Sanitary Reform were strengthened and presented proposals for health that generated achievements in the scope of social and democratic rights with the implementation of the Unified Health System (SUS), promoting universal access to health policies in Brazil (TORNQUIST, 2002; FEUERWERKER, 2005). With these movements, the process of rupture with the medical hegemony began and the work of other professionals, such as nurses, psychologists, physiotherapists, social workers, and occupational therapists was extended to ensure broadened and integrated practices in health care in all contexts, including women's health (FEUERWERKER, 2005).

These movements have contributed to the implementation of laws and programs of integral care to women's health, guaranteeing approaches that reaffirmed their role in society and in the health system, giving the desire of women, as well as to feminine contestations regarding the conditions of gestation and childbirth in the country (BIRMAN, 1999; TORNQUIST, 2002).

These challenges also included the theme of the humanization of childbirth and birth, which has gained strength in the last decade, advocating female protagonism in the process of giving birth and the extinction of obstetric violence, as well as unnecessary or unsupported medical interventions by scientific evidence: the use of indiscriminate oxytocin, unspecified surgical interventions, episiotomies, amniotomy, trichotomy, among others, except in cases of proven need, enabling more positive experience to the childbirth (TORNQUIST, 2002; BRASIL, 2017).

In 1984, the Ministry of Health created the Comprehensive Assistance Program for Women's Health and marked the beginning of the expansion of integral women's care programs, proposing new

guidelines that understand that being a woman is far beyond the care of the home and being a mother (BRASIL, 2004). This program predicts

> educational, preventive, diagnostic, treatment and recovery actions, including the assistance to women in gynecological clinic, prenatal, childbirth, and puerperium, in the climacteric, in family planning, Sexually Transmitted Diseases (STD), cervical cancer and of breast (BRASIL, 2004, p. 17).

Even with advances, the Maternal Mortality Committees point to increases in maternal mortality and, according to Morse et al. (2011),

> [...] the data also suggest higher values in women of lower income and education, black and with little access to care, being an important indicator of living conditions and social injustice (MORSE et al., 2011, p. 624).

A study carried out in 2016 shows that obstetric violence is still very much present shown both in the use of unnecessary medical and surgical resources during the gestational period and in childbirth, as well as "neglect of care, social discrimination, verbal, physical and psychological violence", emphasizing that black and poor women are more frequently abused (ANDRADE et al., 2016, p. 30).

Although prevailing health intervention practices prescribe, mutilate, blame and cause suffering for pregnant women/parturients in the name of risk prevention and market dictates, the programs and laws implemented since the beginning of the SUS contribute to female protagonism in the search for humanized methods during childbirth (TORNQUIST, 2002). These practices seek to rescue respect for the woman's body during childbirth, leading to an expansion of the Public Policies of Humanization of childbirth and birth (TORNQUIST, 2002).

An absolutely important space in the health sector for female protagonism, not only for childbirth, but also for pregnancy is the Basic Health Care (ABS), characterized as the primary level of healthcare and currently composed of a set of strategies and points of care that include the Basic Health Units (UBS), the Family Health Units (USF), the Family Health Support Centers (NASF) and the Street Doctor´s Office. In the basic network, women are followed in their prenatal and postpartum periods. Currently, ABS is expected to be the preferred entry for pregnant women into the health system, and that care for them occurs in an integrated, humanized way and capable of accommodating gestational needs in a longitudinal and continuous way (BRASIL, 2012).

For the UBS staff, it is expected that the care of pregnant women will be possible: to guide women and families for health, family planning and the importance of prenatal care; to meet the needs of pregnant women; carry out home visits; promote educational practices and groups of activities; identify risks and vulnerabilities; perform clinical procedures; to do necessary referrals (BRASIL, 2012).

Groups of pregnant women are becoming increasingly common as a strategy of care in UBS and USF, enabling to extend prenatal care beyond the routine of gynecological examination and care. These groups are idealized by professionals from different professional backgrounds, including occupational therapy.

Occupational therapists who have worked in this field highlight a set of strategies of occupational therapeutic actions that provides qualified listening and breaks with the biomedical models of action in the field of health. Also, they emphasize body approaches and individual or group activities that enable promotion, prevention, health education, and empowerment of women over their body (GALHEIGO, 2007; REIS et al., 2012; ROCHA et al., 2012).

The groups with pregnant women in ABS enables the existence of a sensitive and welcoming space for the individual and collective questions and demands that arise during the gestation period and which are not always accepted in clinical consultations, besides to interaction and exchange of experiences and knowledge among pregnant women, attention to the body, its sensations and emotions (GALHEIGO, 2007; REIS et al., 2012; ROCHA et al., 2012; SILVESTRINI et al., 2014; NASCIMENTO et al., 2017).

Galheigo (2007) highlights that high-risk pregnant women have been the main focus of occupational therapy interventions in the basic health network, such as the case of pregnant women using psychoactive substance, in deprivation of liberty, adolescents, with physical and/or sensory disabilities or in street situations and other forms of social vulnerability.

Gontijo (2007) presents relevant data on the gestation of young people in situations of vulnerability, since he affirms that motherhood has provided the strengthening of the relational insertion axis, with more support and social recognition offered to both pregnant women and their children, and prompted

the young women to seek other alternatives in their insertion in the world of work.

From this universe of possibilities, the relevant data of the research on "corporality of pregnant women" that aimed to report and propose strategies and practices of occupational therapy in this field is shown.

3 Methodological Procedures

We start from a qualitative intervention type approach to carry out this study. Intervention research occurs when the researcher understands that his research object is composed of several social, environmental, collective and individual segments and is affected by his observation. It is to understand the existence exactly in the form in which it is expressed and produced, that is, in events and actions (PAULON; ROMAGNOLI, 2010).

For the data production, different research procedures were used: questionnaire application; field journals to record the perception, observation, and analysis of the researchers; performance of group and body activities.

The questionnaire applied enabled to draw a socioeconomic profile of the participants and to identify some clinical aspects about gestation, covering questions such as age, education level, marital status, sexual orientation, profession, family income, gestational period, clinical intercurrences, births, number of pregnancies, interrupted pregnancies, number of normal deliveries and gestation monitoring sites.

The records in the field diaries contributed to the production of data and memory of the researchers´ and collaborators´ perceptions. The field diary is the fusion of three types of diaries: the field diary (which includes the description of the facts that the researcher has observed), the intimate diary (which refers to the reflections and the perceptions of the researcher based on what was observed) and the research journal (for the recording of the theoretical correlations after the observation of the events) (LOURAU, 2004).

In summary, four meetings were held with a group of pregnant women already in a UBS, held every two weeks, coordinated by a Community Health Agent (ACS) and a nurse in a peripheral region in the city of São Carlos (SP).

It was suggested to propose group and corporal activities for sensitization, interaction and interventional practices, through the construction of other languages, not just written or verbal discourse that could dialogue with the corporeity of pregnant women. Thus, group interactions were used with the use of corporal painting[2], body map[3,] and photovoice[4].

The flow of participation of the group was fluctuating and varied between two and 15 participants, depending on climatic conditions and women's health. This group aimed to promote the socialization and exchange of experiences in pregnant women, at any gestational period, accompanied at UBS.

The first meeting aimed at the presentation of the research, the proposal and the sending of invitations to all the participants of the group. The two subsequent meetings were held within a 15-day interval, with approximately two hours each, with a total of 14 participants. In the last meeting, the results of the research were presented.

The meetings were conducted by the researcher and four other volunteer workers, all of them graduating in occupational therapy, guided by two occupational therapists, assisted by ACS and the nurse responsible for the group.

Considering all the complexity of a gestation, this experience is an intervention device. A device is understood as an element for which visible and enunciated, invisible and unannounced forces and subjectivation forces are generated (DELEUZE, 2005).

The meetings were photographed, recorded and later transcribed. Also, the individual records were systematized in a field diary of the researcher and each of the collaborators, containing analyses of the perception of each and its implications in the group. All material produced was compiled and considered at the time of data analysis of this research.

For the data analysis, the statements of the pregnant women, the expressions enunciated by the materials of the activities and the proposed dynamics, the perceptions reported by the researcher and the collaborators in individual field journals were considered, as well as the theoretical studies previously performed.

With the technique of interpolation of views (FERIGATO, 2013), the thematic categories for the systematization of results were listed, according to the intensity of resonance in the group.

The technique of interpolation of views was proposed by Azevedo (2012) and occurs with the cross-linking of the research devices, with an engendering between the data production modes, not a linear chaining or synthesis. In this perspective,

analyzing the material produced in the meetings, the field diaries, the corporal practices and the bibliographic review is to open and view the statements, to the theoretical and practical productions, to the narratives of different participants of the research, interspersed with possible readings and contributions of the researcher (AZEVEDO, 2012; FERIGATO, 2013; SILVA; FERIGATO, 2017).

Ethical research procedures with human beings have been respected. The field was carried out with the authorization of the direction of the UBS and the team of coordination of the group of the pregnant women. All participants gave their consent in the free and informed consent term, including the use of images, considering the preservation of their facial or nominal identification. All the collection material was stored under the care and responsibility of the researchers. Final and devolutive report on the data constructed in the research were presented and delivered to the participants in the care of the UBS.

4 The Propositions and the Meetings

The first meeting began with the awareness of the participants to create a comfortable, welcoming and trustworthy space for pregnant women, to bring them closer to their own bodies, to promote integration among the collective and also to trigger the conversation body and corporeality.

Then, with the images and examples, the researcher explained to the participants the term corporeity according to the theoretical reference of Merleau-Ponty (1994) and guided them so they could share their experiences as pregnant women, bringing all the transformations and affections for the perception of the body.

Then, pregnant women were invited to perform body paintings in their belly and/or in each other. It was suggested that they try to reproduce symbolically the meaning of gestation for them and, simultaneously, to make photographic records of these paintings, following guidelines of the photovoice methodology.

To conclude the activities, a photo session of the pregnant women with the body paintings was suggested and later revealed and given to each of them as the product of the meetings. Finally, an open and welcoming space was proposed that they could freely express any feelings. At the same time, they were asked to complete the questionnaire and to have any doubts about the subject matter or the procedures performed during the meetings.

In the second meeting, the activity of the collective body map was proposed, whose objective was to answer the following question: "What does the corporality of the pregnant woman mean?", Bringing expressive elements of the pregnant women to the question according to multiple languages, producing different regimes of visibility, statements, enabling objective and subjective ways of responding to the same problem.

Participants were able to express through writing, painting, magazine images and other symbolic forms they found in the materials provided. During the construction of the body map, the women were able to talk to each other, sharing lived experiences and reflections.

Then, the steps of photovoice were followed, so the pregnant women could appreciate, select, describe, caption and share the photos, evaluating and finalizing the activity.

An open and welcoming space was created to finish the meeting for the free expression of the participants, who were also able to give feedback on the processes they experienced during their participation in the meetings.

With the interpolation of the data produced, thematic axes of discussion were created that could encompass the enunciated, visible, objective and subjective corporations in the group of pregnant women.

5 Results

A total of 14 women in the gestational age were 15 to 41 years old were enrolled in the study, five of them were single and nine were married, from middle to low and middle class. They were in gestational periods and number of gestations varied. Eight of them completed elementary school, five completed high school and one were finishing higher education. The average family income ranged from one to four minimum wages, two of them had no declared income. Six women were defined as housewives, three had an employment, four were unemployed, and one says nothing. All of them were close to UBS and the family composition varied (Table 1).

The healthcare is mainly made by the UBS and only three women were following the gestation in other places: one in the Hospital das Clínicas of Ribeirão Preto; one of them in another UBS of the

Table 1. Personal information about pregnant participants.

Pregnant woman	Age	Number of children	Marital status	Complete education	Current occupation	Miscarriage	Average family income (minimum salaries)[5]
1	37	3	Married	Elementary School	Housewife	0	Not declared
2	24	0	Married	Higher education	Teacher	Not declared	More than 2
3	24	2	Married	High school	Unemployed	0	More than 2
4	30	4	Married	High school	Housewife	0	Up to 1
5	30	2	Single	Elementary School	Not declared	0	Not declared
6	23	1	Married	Elementary School	Unemployed	1	Up to 1
7	23	2	Married	High school	Housewife	0	Up to 1
8	41	3	Single	Elementary School	Housewife	2	From 1 to 2
9	15	1	Married	Elementary School	Unemployed	0	From 1 to 2
10	17	2	Married	Elementary School	Unemployed	0	Up to 1
11	17	0	Single	High school	Administrative Assistant	0	From 1 to 2
12	16	0	Single	Elementary School	Housewife	0	From 1 to 2
13	28	1	Single	High school	Garçonete	0	From 1 to 2
14	19	1	Married	Elementary School	Housewife	0	From 1 to 2

Source: data from the questionnaires applied. Elaboration of the authors.

municipality; and one was having consultation with a private doctor.

5.1 Gestation as a device and analysis of the contents

After the analysis of the produced data, three thematic axes were chosen among all the observed aspects in their enunciation, verbal and nonverbal expressions and resonance in the group. They were: sexuality, the dimension of the desire to be a mother, materiality and daily life.

5.2 Sexuality

Historically, the social role of women was determined as to generate, raise and educate their children, placing them in a lower position in power and disadvantage to men (BRASIL, 2004). There was the presence of this condition in the meetings with the women.

On the other hand, since the International Conference on Population and Development (ICPD) in 1994, it is envisaged that reproductive health implies giving people a safe and satisfying sex life, where they have the capacity to reproduce and decide when, how and how often this will happen (CIPD, 1994). The discourses brought by women reflect how their sexuality is produced in the relationship with the partner and how, bodily, the sexual desires pass through them during gestation. It was noticed that almost all the pregnant women decreased the frequency they were related sexually and effectively with the partners, due to the lack of desire, enunciated in some speeches:

> *It felt disgusted by my husband in pregnancy* (Pregnant woman 14).

> *For me, it has decreased. No, it was early. My* [partner] *is suffering in my hand* (Pregnant woman 13).

Sexual desire was shown during the construction of the collective body map (Figure 1). Through body techniques, the overlapping of man's sexuality over woman's, which corresponds to the socio-historical construction on the social roles of each gender and the social function of sexuality, was also identified.

Various moral, social and cultural values can be attributed to sexual practice. In some countries, for example, it is believed that sexual intercourse during pregnancy is dangerous and can cause impotence, infertility, or gestate monsters. In others, such as Nigeria and Japan, sex during pregnancy is encouraged, because it is believed to widen the vagina and smooth labor (ARAÚJO et al., 2012).

Also, physical and biological factors also contribute to changes in sexual desire and libido during

Figure 1. Collective body map with emphasis on the expressions "Will to have sex" and "Will not to have sex".

pregnancy. According to Araújo et al. (2012) belly growth, weight gain, aches, and nausea are factors that may represent a growing annoyance for pregnant women at the time of sexual intercourse.

Considering the uniqueness of each process, it is not possible to state that pregnant women lose desire, decrease or avoid sexual activities. Such changes are present in the process of the same gestation. Thus, the importance of considering and signifying the particular and unique characteristics, process and moment of gestation and of each woman's life is highlighted.

Besides to reflecting the social and cultural significance of sexuality, the participants raised aspects that represent the overlap of the sexual will of man in the relationship, a present issue in their daily lives and many others, regardless of gestation, but when they experience this situation, they are in a process that shows their fragility, because the body is an offer in exchange and bargaining with the partner when it expresses sexual desire and, in this meeting, the present body also reveals annoyances.

> *One of the pregnant women who started the topic on sex asked to whisper in my ear because she said she was ashamed to say she did not feel like having sex during pregnancy* (Diary of the researcher's field).

> *My* [partner] *is also* [suffering] *it is blackmail, especially when I feel like eating something and he does not give me* (Pregnant woman 6).

Another aspect is about the care of the body, also mentioning the relationship with the partner. With the growth of the belly, swelling of the feet, lowering of blood pressure, among other physical and emotional changes that can occur during pregnancy, self-care activities (both necessary and socially constructed) can be compromised. Genital waxing was a trigger for this discussion since the partner complains on these aspects during times of sexual intercourse, but, on the other hand, he does not help in this task. This activity was cited as a desire and frustration for some women.

Finally, touch-related discomforts emerge when coming from someone other than the husband and it is revealed that the understanding of the touch is intertwined with sexuality, causing strangeness and even prejudices that were incorporated during the trajectory of the participants and expressed during the experiences. During the sensitization moment, a touch was proposed among the participants to share the feelings of becoming a mother. Certain strangeness was observed, understanding the touch with sexual connotation and created, at first, a blockage for this experimentation.

> [...] *I cannot deny the explicit confused relationship with the body of the other, the taboo of being touched by another woman, it was causing some shame initially* (Excerpt from collaborator B's field diary).

> *This caused some estrangement: "Why do I have to lay hands on another woman? I have my husband", one speaks. Strangeness for me, that I already said some things about the relationship of those women with their own body and with the bodies of others. After all, we are not used to lovingly touch other bodies, are we?* (Excerpt from the researcher's field diary).

> *I cannot care for my friend, she's needy, she'll want something else* (Pregnant woman 13).

Another related questioning was stated in the questionnaire when the participants were confronted with the issue "sexual orientation" since they understood the answer as obvious since they were pregnant.

> [...] *nor did the pregnant women know what to put into "sexual orientation" and were astonished to have to answer whether they were heterosexual or homosexual. Another astonishment of them occurred when I said that it would have as two women, as a couple, one of them being pregnant and/or having children, by other means* (Excerpt from the field diary of collaborator T.).

At all times, when questions of gender were addressed, the group was cautious and timid in sharing their experiences.

> *I realized that some subjects, for example, sex cause embarrassment to the group as a whole, and difficulty in talking about it. As something that needed to be veiled, as it does in many other spaces without all of society* (Excerpt from the researcher's field diary).

5.3 The dimension of the desire to be a mother

During the meetings, it was noted that the desire for gestation and maternity for the participants of the research is something that directly influences the production of the corporality of pregnant women. To experience motherhood does not mean to wish to exercise motherhood; generating a child may even be unconsciously a result of the social pressure to play the role of being a mother determined for women (STASEVSKAS, 1999).

Planning for pregnancy is a right for all women, but it is a practice little adopted by the Brazilian population in general and little stimulated by health and educational institutions, usually unprepared to receive and guide women of any age in family planning and sexual health (SÃO PAULO, 2010).

We asked the pregnant women participating in this research how it was to receive the positive result for the pregnancy. The answers were quite varied:

> *For me it was a shock, I did not expect it* (Pregnant woman 1).

> *For me it was happy, it was something that I was very happy to see* (Pregnant woman 13).

> *Oh, it's all very new to me, it's my first child, I'm about to find out. Although I wanted to, right before the time* (Pregnant woman 2).

> *Guys, it's horrible! My pregnancy is tragic. I look good after I have the baby. After I got the baby, I get super good* [...] *Wow! For me the pregnancy phase is a phase of acceptance, it is not a phase of joy. God is more!* (Pregnant woman 14).

We have been able to identify that the desire to exercise motherhood is not related to the very event of gestation and motherhood. Regardless of

whether there is previous planning, experiencing the situation means for each woman a meeting with a series of feelings, thoughts, and situations that are mixed in the different experiences. However, there is not always room to report negative aspects that involve this moment.

The statement of the desire to exercise motherhood has diverse influences and it is related to the acceptance, morality, conditioning, and judgment of the good mother or bad mother (STASEVSKAS, 1999), as observed in the following examples:

> *But do you feel that it is in the chest, in the stomach?* (Researcher).
>
> *It's in the chest, in the chest. Neither of these days, I came here in the market with him* [partner] *nor before I became pregnant again I was a cocaine user, you know? I saw a girl in the same situation as me, asking for money to buy. I started to cry in the middle of the street! Then, everyone stopped and stared at my face. But it's because I remembered that I was like that too and I saw the girl doing the same thing* (G 6).
>
> *And do you think that most of the time is crying that chest pain of sadness or also have cries of joy?* (P).
>
> *Oh, both of you. Sadness is more when my son gets ill because since I was a user* [cocaine]*, I did not stay with my son, it was my mother, and everywhere I went he stayed with my mother. And now when I want to be around him, he does not want to. There it gives more sorrow* (G 6).
>
> *And this is going to be different right,* [name]*?* (Nurse).
>
> *Yes, God willing. It is being* (Excerpt from a dialogue between the researcher, the nurse, and the mother (Pregnant woman 6).

On the other hand, we also find women who did not reproduce the desire for motherhood in their bodies:

> [...] *a girl of only 15, who had been impregnated without wanting to, and since then, told me to be in deep sadness, when she thinks of "everything she has lost" and how much she did not want it now* (Excerpt from collaborator B.).
>
> *I was afraid to get depressed at first because I was very sad. I did not want to. I said, "no, I do not want to". I said, "This will be my year", it will be for me. It's the year I do for myself. For me to study, to do my things. "I'll do a lot of things." Here it comes ...* (Pregnant woman 14).

The last statement stated that the desire or lack of desire for the mothering activity may conflict with the desire for other activities, which are also rivals, and motherhood tends to define its priorities and possibilities, and it is the responsibility and dedication in this moment of their lives.

These statements point to the complexity and plurality that surrounds the dimension of desire in the gestation and motherhood, placing the desire to become pregnant on different positions, the desire to be a mother in her real or ideal contexts. They also indicate the complexity, which is the construction of possibilities of converging or diverging the desire to be a mother with the possibilities of maternal and at the same time to carry out other desired occupational activities. They corroborate to this complexity the socioeconomic situation of each pregnant woman, her social determinants, such as ethnicity, color, and life cycle and her personal, family and relational protection network, associated with access to care, legal protection and conditions to guarantee her and her family existence.

5.4 Materiality and the daily life in the gestational period

Among the most significant variations experienced by the women, there are the daily ones, as well as the corporeal transformations that gestation can produce in their lives and in their activities (LUPERINI, 2008).

The comprehension of this daily living must consider the singularity of the subjects and their plural manifestations, considering that

> [...] everyday life always has a spontaneous hierarchy determined by the time (by production, by society, by the place of the individual in society) and it is manifested to the detriment of socioeconomic conditions (HELLER, 2000, p. 40).

It should be pointed out that this study was carried out with low-income women living in the outskirts of a city in the interior of São Paulo and, for the most part, without paid work. Considering this information and that gestation affects the corporeity of women in biological, physical, emotional, psychological, cultural and social levels, we will bring reflections about the daily life, changes, and adaptations that occurred after the discovery of gestation, starting

from what was observed during the meetings, by material elements and actions, statements or visibilities, which materialized as characteristics of these pregnant women:

> *My mood has changed. Very bad moody* (Pregnant 1).
>
> *I got really fat* (Pregnant 2).
>
> *The low pressure has changed* (Pregnant 3).
>
> *Very sleepy* (Pregnant 4).
>
> *I was very gourmand too* (Pregnant 7).
>
> *What has changed is that I get very upset, very sad* (Pregnant 10).
>
> *What changed in me was the stretch marks* (Pregnant 12).
>
> *I just wanted to eat pear with olives. I cannot stand or see them now* (Pregnant 5).
>
> *It is important because the foot cover swells, the pants do not button, the blouse leaves the belly out. The bra ... aff?!* (Pregnant 14).

Physical, physiological and emotional changes directly influence daily living: clothes and shoes are tight, the increased belly can compromise activities, sleep can disrupt daily planning, mood instability can affect the coexistence with other people, among others aspects (SILVA; SILVA, 2009).

> *Crying that before it was little. Today I am crying a lot, very depressed, at first I did not even want to know how to work, I totally stopped working* (Pregnant 13).
>
> *Every hour I feel like going to bed and sleeping* (Pregnant 13).
>
> *I spend the whole night awake; I cannot take it anymore* (Pregnant 2).
>
> *It is, to eat too, is to sit in front of the refrigerator and eat something* (Pregnant 2).
>
> *In the first pregnancy I* [ate brick]*! But I would not eat again. It is an intense, intense desire* (Pregnant 3).

Although we know that some of these changes are common to most pregnancies, these statements refer to the uniqueness of each gestation experienced by each woman. The way in which the corporeality of pregnant women changes is directly related to their life trajectories, to the gestational period, with relationships that surround them.

A study carried out by occupational therapists pointed out that such changes reflect difficulties in performance in rest and sleep activities, shoe-shaping and depilation, sexual activities, functional mobility and community, and in domestic care and services (NASCIMENTO et al., 2017).

In general, the group revealed diverse affectations in the daily life that, in part, there are interferences resulting from the most visible and materialized changes and, in part, it demonstrates daily actions that undergo changes as a result of the way in which the partners, the health services and the society as a whole are related to pregnant women (Figure 2).

Such changes are the result of the historical objectification of the female body, very present in the relation with the present standards of beauty and productivity, which establish characteristics contrary to those experienced by pregnant women or to the sacralization of the body that generates a life. These changes also undergo changes, depending on the socioeconomic and cultural context in which each woman is immersed (GONÇALVES et al., 2014; OLIVEIRA et al., 2014).

6 Occupational Therapy Interventions

In an attempt to understand what this group of pregnant women expected from UBS, besides to clinical biomedical care, the open spaces for sharing

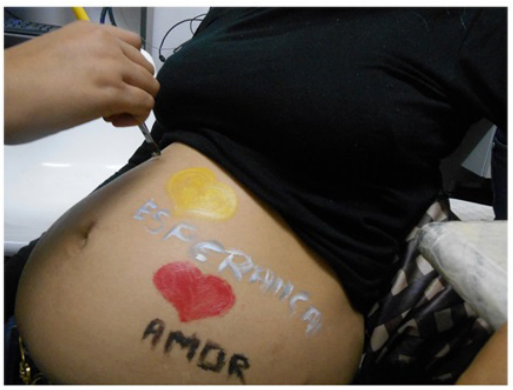

Figure 2. Image and legend result of photovoice (pregnant woman 6).

at the end of each meeting became a powerful space to meet expectations and express some of their demands.

As emphasized by the Prenatal and Puerperium Technical Manual (SÃO PAULO, 2010, p. 192),

> the view of the team that assists women in the pregnancy-puerperal cycle needs to be expanded, not restricted to aspects of biomedical ability. The dynamic and intense transformations of this phase of woman's life should be valued.

Welfare, comfort, and trust were shared feelings between participants and staff. In the report of the pregnant women, the lack of spaces for the exchange of experiences and interaction between them emerged. Although the group already existed with the proposal to promote the meeting between women, the proposal of the intervention research was intended to foster sensitive and subjective territories through experimentation of the body and the doing.

> *I'm relieved.* [...] *thinking about things.* [...] *it was good to be here* [...] *No* [things] *of the body because I already had another child, but things like that right ... But it is ok now* (Pregnant 10).

> *You laughed, had fun, you saw that it's not just you who feels this, right?* (Community Health Agent).

> *I was a little tense. I think because, for those who are housewives and already have children... so it is something that distracts you and takes some of the routine, too, from day to day from home. It was very cool* (Pregnant 7).

> *Oh, I'm feeling light, happy today* (Pregnant 6).

The meetings enables for the pregnant women to talk about subjects of interest, without the obligation to respond to the biomedical demands treated in consultations. As well as the experience reported by Silvestrini et al. (2014), In these meetings, the important result obtained was the construction of a space where the pregnant women interact and exchange experiences in comfortable and welcoming ways.

The production of data during the meetings with pregnant women related to the use of activities conducted by occupational therapists gave us clues and subsidies to list a possible set of actions related to the corporeity of pregnant women within ABS. Among them, there were the accomplishment of activities, dynamics and group techniques with a focus on care beyond what is already done hegemonically by the health sector. Thus, we value the reception, the sensitization, the socialization and the exchange of experiences (Figure 3).

The thematic contents shown by the participants reveal little aspects in the clinical consultations, highlighting the value of attentive and sensitive listening to their demands, without judgments or moralizing discourses; the accomplishment of corporal activities that promote the perception, the empowerment and the confrontation of the changes during the gestational period; the performance of meaningful activities for women to produce pleasurable experiences that place women as central to the activity and not just the baby; the performance of groups that reflect on the role of women and the relational and social contexts that permeate motherhood, among others.

Also, it is possible to promote actions together with other professionals and other sectors to broaden all the perspectives of the health field for a more integrated and transversal attention; to include partners and other family members as support networks for the experience of gestation and family planning.

Among the many examples cited, it is evident that the emphasis of occupational therapy would not be only gestation, the mother, the body nor the baby, but these elements in relation; in the relationship to each other and to the world around them, that is, the pregnant corporality in action, in the focus of their experience of the world.

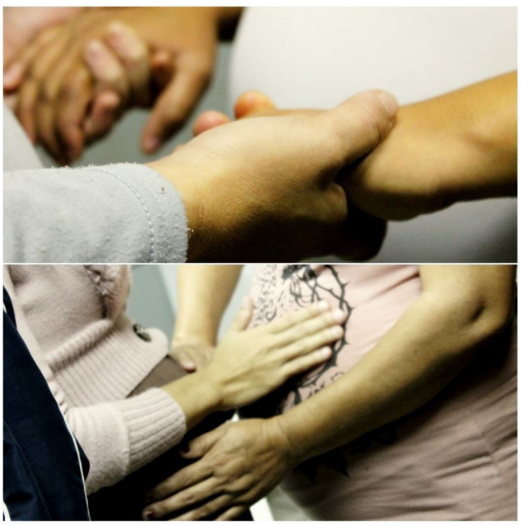

Figure 3. Touches and exchanges between the participants of the group.

Bezerra et al. (2009) state that occupational therapists in women's health care have opted for group approaches to offer support and encouragement to the participants, building a support network among them. For this, they use expressive activities, therapeutic workshops and other artistic techniques (drawing, painting, collage, decoupage, etc.), with the proposal of potentializing daily life, expressing feelings, affective and experiential exchanges, self-esteem and self-knowledge, addressing issues that concern both self-care and baby care.

In this sense, the gestational process is understood not only as the generator of a baby and a mother (father, family, among other networks) but of new corporeities, desires, and fears, new family and social relationships, new activities, new everyday life. It includes a new hall of possible actions, of bodily and existential trials that can be object of occupational therapy, not for the prescription of more or less adequate occupational activities, but for the production of a significant gestational experience, protagonist and implied with himself and his possibilities.

7 Final Considerations

Considering all the complexity of the woman in the gestational process, it is concluded from this experience that the demands that reach the health spaces are increasingly complex and require transversal and integrated actions of the ABS professionals. When we provide host territories for all demands, there are many possibilities that can emerge. This does not exclude the importance of traditional clinical consultations, given the importance of prenatal care and the impact of this process on health indicators in Brazil.

Regarding to women's health care in ABS, occupational therapists have been concerned with receiving and listening, especially in performing groups and bodily activities that provide spaces for action, empowerment and coping with situations before gestation, as the literature pointed out. In the same direction, this research showed to be able to act with the participants through the proposition of significant activities.

From the investigation of the corporeity, in its wide understanding, there are diverse experiences of being pregnant in the biological, physical, physiological, emotional, social, relational, economic, cultural and gender contexts that sometimes go unnoticed in the traditional clinical visits.

Thus, we also allowed the meeting with this sensitive territory, listening, exchanges and recognition of the most subjective or taboo needs, promoting a more meaningful contact between participants and staff, in a more human and corporeal interaction, that is, an effect was evidenced therapeutic, care, as well as the production of research data, as suggested by research-intervention.

The proposed activities promoted awareness and self-perception, collaborating in the production and expression of individual and collective corporations, showing that there is a potential in working with the body approaches in groups with this population, according to different intervention strategies.

The topics of sexuality, desire in the motherhood, and everyday materiality and transformations emerged as central aspects when the issue of the corporality of pregnant women was approached. Based on this finding, the potential of occupational therapy interventions with pregnant women is capable of producing a displacement in the way that the pregnant body is traditionally approached, as well as emphasizing the daily life of the gestation process, seeking to produce an active gestational experience, including the limits and potentialities of each experience.

Therefore, from the actions directed to the corporeity, the occupational therapeutic actions are related to the reception of this body, the integral care to its health, the interconnection with other sectors and contexts of the life, the performance of groups for listening and practices that produce the perception of the body, the expression of corporeities and the creation of sensitive spaces with an emphasis on the production of care, autonomy, emancipation and protagonism of women in their daily lives.

References

ALMEIDA, M. V. M. *Corpo e Arte em Terapia Ocupacional*. Rio de Janeiro: ENELIVROS, 2004.

ANDRADE, P. O. N. et al. Fatores associados à violência obstétrica na assistência ao parto vaginal em uma maternidade de alta complexidade em Recife, Pernambuco. *Revista Brasileira de Saúde Materno Infantil*, Recife, v. 16, n. 1, p. 29-37, 2016. Disponível em: <http://www.scielo.br/pdf/rbsmi/v16n1/1519-3829-rbsmi-16-01-0029.pdf>. Acesso em: 13 abr. 2017.

ARAÚJO, N. M. et al. Corpo e sexualidade na gravidez. *Revista da Escola de Enfermagem da USP*, São Paulo, v. 46, n. 3, p. 552-558, 2012. Disponível em: <https://

www.revistas.usp.br/reeusp/article/view/40980/44497>. Acesso em: 08 mar. 2018.

AZEVEDO, B. M. S. *O ensino da gestão no curso de graduação de medicina da FCM/UNICAMP:* possíveis encontros entre universidade e serviços de saúde. 2012. 159 f. Dissertação (Mestrado em Saúde Pública) – Universidade Estadual de Campinas, Campinas, 2012.

BAGAGLI, B. P. Orientação sexual na identidade de gênero a partir da crítica da heterossexualidade e cisgeneridade como normas. *Letras Escreve*, Macapá, v. 7, n. 1, p. 137-164, 2017. Disponível em: <http://periodicos.unifap.br/index.php/letras/article/view/3073>. Acesso em: 17 jan. 2018.

BEZERRA, T. C. C. et al. A construção e ressignificação das práticas da terapia ocupacional na estratégia saúde da família a partir da residência multiprofissional. *SANARE*, Sobral, v. 8, n. 2, p. 52-62, 2009. Disponível em: <https://sanare.emnuvens.com.br/sanare/article/viewFile/19/15>. Acesso em: 08 mar. 2018.

BIRMAN, J. *Cartografias do feminino*. São Paulo: Editora 34, 1999.

BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. *Política nacional de atenção integral à saúde da mulher*: princípios e diretrizes. Brasília: Ministério da Saúde, 2004. Disponível em: <http://bvsms.saude.gov.br/bvs/publicacoes/politica_nac_atencao_mulher.pdf>. Acesso em: 17 mar. 2017.

BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. *Diretrizes do NASF – Núcleo de Apoio à Saúde da Família.* Brasília: Ministério da Saúde, 2009. Disponível em: <http://bvsms.saude.gov.br/bvs/publicacoes/caderno_atencao_basica_diretrizes_nasf.pdf>. Acesso em: 13 abr. 2017.

BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. *Atenção ao pré-natal de baixo risco*. Brasília: Ministério da Saúde, 2012. Disponível em: <http://bvsms.saude.gov.br/bvs/publicacoes/cadernos_atencao_basica_32_prenatal.pdf>. Acesso em: 17 mar. 2017.

BRASIL. Portal da Saúde. *Rede Cegonha*. Disponível em: <http://dab.saude.gov.br/portaldab/ape_redecegonha.php>. Acesso em: 03 jun. 2017.

CONFERÊNCIA INTERNACIONAL SOBRE POPULAÇÃO E DESENVOLVIMENTO – CIPD. *Relatório final.* Cairo: CNPD/ FNUAP, 1994. Disponível em: <http://www.unfpa.org.br/Arquivos/relatorio-cairo.pdf>. Acesso em: 17 mar. 2017.

CRUZ, M. H. S. A Crítica Feminista à Ciência e Contribuição à Pesquisa nas Ciências Humanas. *Revista Tempos e Espaços em Educação*, São Cristóvão, v. 7, n. 12, p. 15-27, 2014. Disponível em: <https://seer.ufs.br/index.php/revtee/article/view/2949>. Acesso em: 30 maio 2017.

DAVY, C. et al. Aspects of the resilience and settlement of refugee youth: a narrative study using body maps. *Cadernos de Terapia Ocupacional da UFSCar*, São Carlos, v. 22, n. 2, p. 231-241, 2014. Disponível em: <http://dx.doi.org/10.4322%2Fcto.2014.045>. Acesso em: 13 abr. 2017.

DELEUZE, G. *Foucault*. São Paulo: Brasiliense, 2005.

DUARTE, L. F. D.; LEAL, O. F. (Org.). *Doença, sofrimento, perturbação*: perspectivas etnográficas. Rio de Janeiro: Editora FIOCRUZ, 1998. Disponível em: <http://books.scielo.org/id/yw42p/02>. Acesso em: 17 mar. 2017.

FERIGATO, S. H. *Cartografia dos centros de convivência de Campinas:* produzindo redes de encontros. 2013. 320 f. Tese (Doutorado em Saúde Coletiva) – Universidade Estadual de Campinas, Campinas, 2013.

FEUERWERKER, L. M. Modelos tecnoassistenciais, gestão e organização do trabalho em saúde: nada é indiferente no processo de luta para a consolidação do SUS. *Interface - Comunicação, Saúde, Educação*, Botucatu, v. 9, n. 18, p. 489-506, 2005. Disponível em: <http://www.scielosp.org/pdf/icse/v9n18/a03v9n18.pdf>. Acesso em: 17 mar. 2017.

GALHEIGO, S. M. Domínios e temáticas no campo das práticas hospitalares em terapia ocupacional: uma revisão da literatura brasileira de 1990 a 2006. *Revista de Terapia Ocupacional da Universidade de São Paulo*, São Paulo, v. 18, n. 3, p. 113-121, 2007. Disponível em: <http://dx.doi.org/10.11606/issn.2238-6149.v18i3p113-121>. Acesso em: 13 abr. 2017.

GONÇALVES, L. et al. Parto domiciliar como um dispositivo de humanização das práticas de saúde no Brasil. In: BRASIL. Ministério da Saúde. *Cadernos HumanizaSUS:* Humanização do parto e nascimento. Brasília: Ministério da Saúde, 2014. p.232-254. Disponível em: <http://www.redehumanizasus.net/sites/default/files/caderno_humanizasus_v4_humanizacao_parto.pdf>. Acesso em: 13 abr. 2017.

GONTIJO, D. T. *Adolescentes com experiência de vida nas ruas*: compreendendo os significados da maternidade e paternidade em contexto de vulnerabilidade. 2007. 394 f. Tese (Doutorado Ciências da Saúde) – Universidade Federal de Goiás, Goiânia, 2007.

HELLER, A. *O cotidiano e a história*. São Paulo: Paz e Terra, 2000.

LOURAU, R. Processamento de texto. In: ALTOÉ, S. (Org.). *René Lourau*: analista institucional em tempo integral. São Paulo: Hucitec, 2004. p. 199-211.

LUPERINI, K. *Corporeidade gestante*: o discurso de corpo de mulheres em idade adulta e madura e dos pais das crianças. 2008. 318 f. Dissertação (Mestrado em Educação Física) – Universidade Metodista de Piracicaba, Piracicaba, 2008. Disponível em: <https://www.unimep.br/phpg/bibdig/pdfs/2006/JFKXAPLOOOGW.pdf>. Acesso em: 30 maio 2017.

MATOS, M. I. S. Delineando corpos: as representações do feminino e do masculino no discurso médico (São Paulo 1890-1930). In: MATOS, M. I. S.; SOIHET, R. (Org.). *Corpo feminino em debate.* São Paulo: Editora UNESP, 2003. p. 107-127. http://dx.doi.org/10.7476/9788539303311.

MEDEIROS, M. H. R. *Terapia Ocupacional*: um enfoque epistemológico e social. São Carlos: EdUFSCar, 2010.

MERLEAU-PONTY, M. *Fenomenologia da Percepção*. São Paulo: Martins Fontes, 1994.

MORSE, M. L. et al. Mortalidade materna no Brasil: o que mostra a produção científica nos últimos 30 anos? *Cadernos de Saúde Pública*, Rio de Janeiro, v. 27, n. 4, p. 623-638, 2011. Disponível em: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2011000400002&lng=en&nrm=iso>. Acesso em: 13 abr. 2017.

NASCIMENTO, C. R. F. et al. Ações de terapia ocupacional com gestantes na rotina diária. *Revista Interinstitucional Brasileira de Terapia Ocupacional*, Rio de Janeiro, v. 1, n. 5, p. 556-573, 2017. Disponível em: <https://revistas.ufrj.br/index.php/ribto/article/view/10049>. Acesso em: 08 mar. 2018.

OLIVEIRA, D. L. et al. A atenção materna e infantil e marcadores socioculturais. In: BRASIL. Ministério da Saúde. *Cadernos HumanizaSUS*: Humanização do parto e nascimento. Brasília: Ministério da Saúde, 2014. p.47-58.

PAULON, S. M.; ROMAGNOLI, R. C. Pesquisa-intervenção e cartografia: melindres e meandros metodológicos. *Estudos e Pesquisas em Psicologia*, Rio de Janeiro, v. 1, n. 1, p. 85-102, 2010. Disponível em: <http://www.revispsi.uerj.br/v10n1/artigos/pdf/v10n1a07.pdf>. Acesso em: 17 mar. 2017.

REIS, F.; GOMES, M. L.; AOKI, M. Terapia ocupacional na Atenção Primária à Saúde: reflexões sobre as populações atendidas. *Cadernos de Terapia Ocupacional da UFSCar*, São Carlos, v. 20, n. 3, p. 341-350, 2012. Disponível em: <http://www.cadernosdeterapiaocupacional.ufscar.br/index.php/cadernos/article/view/678>. Acesso em: 17 mar. 2017.

ROCHA, E. F.; PAIVA, L. F. A.; OLIVEIRA, R. H. Terapia ocupacional na Atenção Primária à Saúde: atribuições, ações e tecnologias. *Cadernos de Terapia Ocupacional da UFSCar*, São Carlos, v. 20, n. 3, p. 351-361, 2012. Disponível em: <http://dx.doi.org/10.4322/cto.2012.035>. Acesso em: 17 mar. 2017.

SÃO PAULO. Secretaria de Estado da Saúde de São Paulo. Coordenadoria de Planejamento em Saúde. Assessoria Técnica em Saúde da Mulher. *Atenção à gestante e à puérpera no SUS – SP*: manual técnico do pré-natal e puerpério. São Paulo: SES, 2010. Disponível em: <http://www.saude.sp.gov.br/resources/ses/perfil/gestor/destaques/atencao-a-gestante-e-a-puerpera-no-sus-sp/manual-tecnico-do-pre-natal-e-puerperio/manual_tecnicoii.pdf>. Acesso em: 13 abr. 2017.

SÃO PAULO. Governo Estadual de São Paulo. *Piso Salarial Regional de SP*. Disponível em: <http://www.emprego.sp.gov.br/pesquisa-e-servicos/piso-salarial-regional-de-sp/>. Acesso em: 23 ago. 2016.

SILVA, A. P. D.; FERIGATO, S. H. Saúde mental e trabalho: diálogos sobre direito, desejo e necessidade de acesso. *Cadernos Brasileiros de Terapia Ocupacional*, São Carlos, v. 25, n. 4, p. 803-816, 2017. Disponível em: <http://www.cadernosdeterapiaocupacional.ufscar.br/index.php/cadernos/article/view/1689/914>. Acesso em: 23 dez. 2017.

SILVA, L. J.; SILVA, L. R. Mudanças na vida e no corpo: vivências diante da gravidez na perspectiva afetiva dos pais. *Escola Anna Nery Revista de Enfermagem*, Rio de Janeiro, v. 13, n. 2, p. 393-401, 2009. Disponível em: <http://dx.doi.org/10.1590/S1414-81452009000200022>. Acesso em: 13 abr. 2017.

SILVESTRINI, M. S.; CARDOSO, M. L. M.; REGO, B. R. Desafios na construção de um grupo de gestantes na Unidade de Saúde da Família. *Cadernos de Terapia Ocupacional da UFSCar*, São Carlos, v. 22, n. 3, p. 603-607, 2014. Disponível em: <http://dx.doi.org/10.4322%2Fcto.2014.082>. Acesso em: 13 abr. 2017.

SCOTT, J. W. Gênero: uma categoria útil de análise histórica. *Educação & Realidade*, Porto Alegre, v. 20, n. 2, p. 71-99, 1995.

STASEVSKAS, K. O. *Ser mãe*: narrativas de hoje. 1999. 195 f. Dissertação (Mestrado em Saúde Pública) - Universidade de São Paulo, São Paulo, 1999. Disponível em: <http://www.teses.usp.br/teses/disponiveis/6/6136/tde-16032005-141212/pt-br.php>. Acesso em: 13 abr. 2017.

TORNQUIST, C. S. Armadilhas da nova era: natureza e maternidade no ideário da humanização do parto. *Rev. Estudos Feministas*, Florianópolis, v. 2, n. 10, p. 483-492, 2002. Disponível em: <http://www.scielo.br/pdf/ref/v10n2/14972>. Acesso em: 13 abr. 2017.

WANG, C. C. et al. Photovoice as a participatory health promotion strategy. *Health Promotion International*, Australia, v. 13, n. 1, p. 75-86, 1998. Disponível em: <https://doi.org/10.1093/heapro/13.1.75>. Acesso em: 13 abr. 2017.

Author's Contributions

All authors participated in the preparation, analysis and review of the text, responsible for their content and all of them have approved the final version of the text.

Funding Source

PIBIC/CNPq/UFSCar - Programa de Iniciação Científica da Universidade Federal de São Carlos – UFSCar.

Notes

[1] The term cisgen is used to refer to a person whose birth sex matches social expectations about their gender identity. On the other hand, transgender is the person whose sex of birth does not correspond to social expectations about their gender identity (BAGAGLI, 2017). Considering the existence of gender and transgender women, it is worth mentioning that gestation is a biological condition for cisogenic women and transgender men, that is, people born with biologically "feminine" bodies and who were born and maintained with uterus.

[2] Body painting consisted of free painting of the belly, according to the desire of women and their projections regarding the gestation.

[3] The body map consists of reproducing a copy of the body in full size and filling it with paintings, drawings, cutouts, and collages, among other techniques, to approach a certain subject, starting from an initial question (DAVY et al., 2014).

[4] Photovoice is a tool used to produce data in surveys to show the participants' voices through photographic records and captions built by the research subjects. After the presentation of the research object, the participants take photos and then, with these prints, they produce captions that explain what that image record means to answer the question asked (WANG et al., 1998). In this research, the participants were asked to register the pregnant corporality that they saw while performing the body paintings.

[5] To calculate the average family income, data from the website of the São Paulo state government (SÃO PAULO, 2016) were used, according to the minimum wage of R$ 1,000.00, according to Law no. 16,162, approved on March 14, 2016 (GOVERNMENT OF THE STATE OF SÃO PAULO, 2016).