

## Gender issues in the antenatal nursing consultation: perceptions of resident nurses

Questões de gênero na consulta pré-natal de enfermagem: percepções das enfermeiras residentes

Cuestiones de género en la consulta prenatal de enfermería: percepciones de las enfermeras residentes

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**Abstract: Objective:** to describe the perceptions of resident nurses in the process of qualifying for antenatal care about gender issues in the nursing consultation. **Method:** qualitative study, carried out with twelve nurses in qualification, in the modality of residency, in antenatal care services, in the city of Rio de Janeiro. The semi-structured interviews took place from October to November 2016. Thematic content analysis was applied. **Results:** gender norms are related to traditional values and behaviors associated with maternity and paternity. The inequities arising from these norms are seen as the cause of violence against women and limited male involvement in pregnancy. There are restrictions from a gender perspective on services, although there are men who seek more active parenting and same-sex couples who resort to antenatal care. **Conclusion:** intervention proposals focusing on this perspective are necessary in antenatal care and professional qualification, individually and collectively.

**Descriptors:** Gender and health; Nursing; Antenatal care; Sexual and gender minorities; Reproductive health

**Resumo: Objetivo:** descrever as percepções das enfermeiras residentes em processo de qualificação para a assistência pré-natal acerca das questões de gênero na consulta de enfermagem. **Método:** estudo qualitativo, realizado com doze enfermeiras em qualificação, na modalidade de residência, nos serviços de atenção pré-natal, no município do Rio de Janeiro. As entrevistas semiestruturadas ocorreram de outubro a novembro de 2016. Aplicou-se a análise de conteúdo temática. **Resultados:** as normas de gênero relacionam-se com valores e comportamentos tradicionais associados à maternidade e paternidade. As iniquidades advindas dessas normas são vistas como a causa da violência às mulheres e do limitado envolvimento masculino na gestação. Há restrições de uma

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perspectiva de gênero nos serviços, apesar de haver homens que buscam uma paternidade mais ativa e casais homoafetivos que recorrem ao atendimento pré-natal. **Conclusão:** propostas de intervenção com enfoque nessa perspectiva são necessárias na assistência pré-natal e qualificação profissional, em âmbito individual e coletivo.

**Descritores:** Gênero e saúde; Enfermagem; Cuidado pré-natal; Minorias sexuais e de gênero; Saúde reprodutiva

**Resumen: Objetivo:** describir las percepciones de enfermeras residentes en proceso de calificación para atención prenatal sobre temas de género en la consulta de enfermería. **Método:** estudio cualitativo, realizado con doce enfermeras en calificación, modalidad de residencia, en servicios de atención prenatal, en la ciudad de Rio de Janeiro. Las entrevistas semiestructuradas ocurrieron de octubre a noviembre de 2016. Se aplicó el análisis de contenido temático. **Resultados:** normas de género están relacionadas con valores y comportamientos tradicionales asociados a maternidad y paternidad. Las desigualdades de estas normas son la causa de la violencia contra la mujer y de la limitada participación masculina en el embarazo. Hay restricciones desde una perspectiva de género en los servicios, aunque algunos hombres busquen una paternidad más activa y parejas homoafectivas recurran a la atención prenatal. **Conclusión:** propuestas de intervención centradas en esta perspectiva son necesarias en la atención prenatal y calificación profesional, individual y colectiva.

**Descriptor:** Género y salud; Enfermería; Atención prenatal; Minorías sexuales y de género; Salud reproductiva

## Introduction

The antenatal care aims to promote health and prevent maternal and neonatal morbidity and mortality. It is expected that health professionals provide qualified care and guide women and their partners on the social, cultural, emotional and psychological aspects that involve pregnancy, childbirth and birth.<sup>1</sup>

In relation to pregnant women classified as at usual risk and without associated morbidities, there is a predominance of this assistance in public services of Primary Health Care (PHC) in Brazil, as occurs in Primary Care and Family Health Units, with nursing having a relevant participation at that level of attention. Among other duties, nurses carry out nursing consultations privately and promote educational activities, along with other health professionals.<sup>1-2</sup>

Therefore, it is expected that nursing training develop in these professionals the appropriate skills and abilities so that they exercise the profession in a critical and reflective way, with an understanding of the social determinants of health, in favor of integrality, equity,

humanization and quality of health care for the population.<sup>2</sup> However, despite the wide coverage of antenatal care, social inequities that impact the results of care are still observed, such as those associated with class, gender and race or ethnicity.<sup>1-2</sup> For example, women with black or brown skin color and with a lower socioeconomic level, they have lower rates of antenatal adequacy compared to other pregnant women, which increases the risk of negative pregnancy outcomes for these women.<sup>3</sup>

As for gender, the traditional social roles attributed to women and men still tend to be reinforced in health care, in which women are seen with less authority than men, are more devalued and subject to disrespect, verbal abuse and coercive or not consented procedures. However, there is a fundamental human right to gender equality, which must be respected in order to achieve a democratic and more egalitarian society.<sup>4</sup>

In view of the magnitude of social inequities in the world, the United Nations has established the Sustainable Development Goals (SDG) in order to reduce poverty, promote prosperity and the well-being of all people and protect the environment. To this end, it constituted an agenda of goals to be reached by 2030 by its member countries, including Brazil. The fifth SDG aims to achieve gender equality and the empowerment of women and girls, in order to reduce the social inequalities to which half of the world population is exposed because of the simple fact of being a woman.<sup>4-5</sup>

It should be noted that gender refers to roles, behaviors, activities, opportunities and attributes based on different levels of power within society; being distinct from the binary categories of biological sex, although it interacts with them. Their understanding, therefore, requires an indulgence of the complex social processes that operate at the interpersonal level, institutions and society as a whole. Therefore, gender is a determinant of health, since it is interrelated with other factors of inequality, discrimination, marginalization and social exclusion, whose effects on the health and well-being of individuals are complex.<sup>5</sup>

In the field of health, women and men are strongly subject to social normalizations, commonly expressed by representations of maternity and paternity permeated by traditional values that are restrictive of egalitarian social roles. In this way, gender norms contribute to shaping an unequal system in which governmental programs and actions related to maternity emphasize the figure of the mother, which enables the birth of the child, and situate the father as an adjunct, relegating important themes such as unwanted pregnancy, abortion, violence, among others.<sup>6</sup>

Faced with these issues, antenatal care is intended to be a moment of welcoming and sensitive listening, as well as making it possible to respect the dignity and autonomy of the pregnant woman, to favor the active participation of the partner and to promote gender equality in the experiences of maternity and paternity. Therefore, it is expected that the nursing professional will demonstrate sensitivity and skills to address gender issues at this point of reproductive life.<sup>7</sup>

Despite these premises, the current socio-cultural and political context has aroused perspectives that go against gender equality in the field of health. In view of this, the involvement of all social actors defending human rights is required to avoid possible setbacks and losses from achievements in the field of sexual and reproductive rights.<sup>8</sup>

Faced with these challenges for the promotion of gender equality in health, it is expected that nurses are qualified for antenatal care in order to develop sensitivity and competencies in accordance with the goals set out in the SDG and in the Política Nacional de Atenção Integral à Saúde da Mulher – PNAISM (National Policy for Comprehensive Women’s Health Care, in free translation). In the face of such challenges and recommendations, this research was proposed based on the following question: how do nurses in the process of qualifying for antenatal care perceive gender issues in the nursing consultation? It is noteworthy that this consultation is a practice which is private to the nurse, established by the health programs of Primary Care and

Women's Health in Brazil. Among other actions, this professional develops antenatal consultation for pregnant and healthy women, assuming an important role in improving access and qualification of care, in accordance with the recommendations of health programs - which include gender equity -, in order to obtain better results and prevent negative maternal and neonatal outcomes.

The study aimed to describe the perceptions of resident nurses in the process of qualifying for antenatal care about gender issues in the nursing consultation.

## Method

A qualitative descriptive study, carried out with resident nurses in the process of qualifying for antenatal care, in public PHC services in the city of Rio de Janeiro. The participating nurses were enrolled in nursing residency programs coordinated by a public Higher Education Institution (HEI).

The choice for this group was due to the fact that it was constituted, mainly by professionals who had recently completed the undergraduate nursing course, which provides training for antenatal care and nursing consultation. In this sense, it was assumed that the residency program promotes practical in-service experiences that expand or enhance the skills and abilities previously acquired at the undergraduate level.

Nurses in the qualification process for antenatal care for pregnant women at usual risk, enrolled in residency programs, who performed or participated in nursing consultations were included in the research. Were excluded residents who had been employed for less than two months in this type of assistance, considering the start of their activities in the program.

Participating nurses were selected intentionally, from an eligible group of 28 nurses enrolled in residency programs in obstetric nursing and family health, whose in-service training

includes antenatal care services, with nursing consultations and in the context of PHC. The eligible nurses were invited to participate in the research at the end of the weekly theoretical classes of their respective residency programs at the HEI. When they showed interest in participating and based on the observance of the inclusion and exclusion criteria described, they were contacted for scheduling of the interviews.

The gathering of eligible participants ceased when there was a recurrence of the themes that emerged from the nurses' speeches about gender issues in the antenatal nursing consultation, which determined the end of the interviews. In total, 12 nurses were interviewed. Data collection was carried out from October to November 2016.

We chose to conduct the interviews in the classroom of the respective programs, before or after the theoretical classes, due to the fact that it is a more reserved environment for granting the interview. The individual interviews were conducted, under the supervision of a researcher of the team, by previously trained nursing students, as well as guided by a semi-structured script, previously tested with two volunteer nurses, whose pilot interviews were excluded.

The script consisted of three questions whose objective was to characterize the participants regarding their age, the time they completed their undergraduate nursing course and the length of time working in antenatal consultations during their residency. These questions were added to open questions related to gender issues in the antenatal nursing consultation, namely: Tell me about the gender issues that arise during pregnancy, those that are specific or related to the female and male gender during this period and how these issues should be addressed in the antenatal nursing consultation.

The data were analyzed using thematic content analysis. Pre-analysis was carried out through the organization of the interviews and an exhaustive reading of the textual contents to identify the text clippings related to the object of study; exploration of the material using the semantic equivalence of the codes, according to the corresponding themes, and construction of

the thematic categories; inference and interpretation based on the scientific literature on gender issues in maternal health care and the antenatal period.<sup>9</sup>

The study complied with the regulatory standards for research involving human beings, having been approved by the Research Ethics Committee of the University of the State of Rio de Janeiro on April 17, 2015, obtaining Opinion No. 1,028,107 and CAAE 40647415.9.0000.5282. The codification was adopted to guarantee the anonymity of the participants, by means of the letter E followed by the order in which the interviews were granted: E1, E2, E3, and so on. All participants signed the Free and Informed Consent Form.

## **Results**

The 12 nurses in qualification in antenatal care, participating in the study, were predominantly women, aged between 24 and 33 years. Only two professionals were male. It was decided to designate the participants by the predominant gender among them, the female.

These professionals had completed their undergraduate degree in nursing about 24 months ago, on average, ranging from ten months to four years, and had worked in antenatal nursing consultations for two to nine months, since the beginning of their qualification, in PHC units. This group of participants consisted of five nurses enrolled in the Residency Program in Obstetric Nursing and seven professionals who were attending the Family Health Nursing Residency.

Thematic content analysis enabled the construction of two categories: Gender stereotypes perceived by resident nurses in the antenatal nursing consultation and Promotion of gender equity in antenatal care.

### **Gender stereotypes perceived by resident nurses in the antenatal nursing consultation**

Nurses consider that maternity and paternity are structured by the gender roles traditionally attributed to women and men. The issues and care of pregnancy, childbirth and children are the responsibility of women, while men have the responsibility of supporting the family.

*Society imposes that it is the woman who has to take care of the child. It is the woman who participates, but the man just stays there and helps almost with nothing. (E11)*

*This issue of raising a child, the woman has this obligation to raise and educate, and the man thinks that it is not his attribute. (E5)*

As for these limitations, nurses characterize pregnant women by their fragility and submission in relation to the male gender, as shown by the following statements:

*In the man, I see more of this issue of authority and a greater empowerment. He has more power than the woman in a relationship, it is the view that I have of all antenatal consultations when they appear, I already know that. So, when you have this matter of gender, when you have this matter of the strength of who runs the family, he is who rules and works. Not her, she is pregnant and at home. So, he ends up getting carried away. (E6)*

*The woman can become very fragile due to the [gestational] changes in her body. She becomes infinitely more fragile, because she is not within the standards set by society as a whole and perhaps even established within the family. I often see women who are concerned about their bodies: What now? I'm fat and my husband is going to look for a thinner woman! Then you stop and think: You can't hear that in the 21st century! However, you hear it a lot. It's tough. (E11)*

In the nurses' perception, gender inequities are associated with situations of violence and the limited social support that women experience during pregnancy.

*The woman is full of doubts, wants to seek support from people and they do not always provide support. The issue of violence happens a lot during pregnancy, more than you think. (E1)*



*Pregnancy can come from a sex that they didn't want to have, but did to please. A woman who did not want to become pregnant, but became pregnant because of the husband who pressures her or because, if they don't give in, the husband looks for another. (E8)*

*When you think of a woman who is being abused in relation to the matter of work, sometimes she has a male boss and she is very submissive with labor issues and is afraid of being beaten in some way. Psychological violence is very common, especially with pregnant women (E10)*

With regard to partners, the participants recognize that there is a movement for change in the traditional father role, as there are men who seek to get involved with the partner's pregnancy and exercise a more active paternity.

*Society imposes that the woman has to take care of the child, it is the woman who participates more. And in the end, the man just stands there and does almost nothing. But it is already changing with the matter of the companion and the father present in the joint accommodation. We try all the time to bring the partner to help the woman in the taking care and that he has this duty too. At first, there was prejudice, but they are already more open. Some have some resistance, usually men of the older generation, but others have already come more open. (E12)*

Regarding gender minorities, nurses report that same-sex couples seek antenatal care at the services where they work. These couples raise challenges to the organization of antenatal care, traditionally designed for heterosexual couples, which mobilizes prejudice attitudes and exposes the existing limitations in addressing gender issues in the daily care.

*I think there is gender and the gender identity. For me, gender is when the person is male or female. Identity is how they identify themselves, they can be a man, but identify as a woman and vice versa. I already had a girl in antenatal care who was lesbian and had a girlfriend, but they fought. She went to a nightclub and drank, had sex with a guy, got pregnant and maintained the pregnancy. But there is no gender approach in antenatal*

*care, the one I participated in did not have this approach. People do not address this gender issue in antenatal care. Unfortunately, they don't know how to apply it. (E4)*

*The woman has this matter of carrying everything on her back, even if she has a partner. If she already suffers as a heteronormative couple, a homonormative couple is even more complicated for society. It should be normal for us to treat this type of couple, but the country is ultra-prejudiced, sexist and LGBTphobic. (E2)*

Thus, the testimonies of resident nurses corroborate the assertions about the limitations of the gender approach in nursing education, as they recognize that there are prejudice attitudes against homosexual couples in antenatal care and that themselves experience moral conflicts due to their personal values grounded in heteronormativity.

*I don't know how it is now, but the gender approach was practically zero in my undergraduate studies, very little, towards the end. And there was also a student who did the monography on gender, but it is rarely addressed. I think I have difficulty in this matter, especially in practice. It's not that I'm prejudiced, I don't know if you understand me. I didn't have this creation because I come from a very traditional family and this is not natural [homosexuality]. I don't see it as naturally, although I don't judge, but there are things that still have an impact on me. (E8)*

### **Promotion of gender equity in antenatal care**

Participants consider that encouraging female empowerment in antenatal nursing consultations is imperative for tackling gender inequalities that are still rooted in society.

*Empower women, the role they must play and not simply feel underestimated or less. It is really empowering the woman with her power, the position of equality in the world and in the [labor] market, the importance of being proactive and having her space recognized in society. And discuss this issue with the couple and the family as a whole. (E9)*

Nurses highlight the importance of the ethical attitude of the nursing professional during the antenatal consultation, which includes professional secrecy; the attitude of welcoming the woman, partner and family; and the creation of bonds and open dialogue, as expressed in the following statements:

*So, first is professional secrecy. Demonstrate your professional secrecy, you can maintain her care. And you have to make it clear to her that everything that is talked in there will not be passed on to anyone. No one is going to expose her life. (E7)*

*You must have empathy. If you have empathy and show your professional secrecy, you can win this woman. If you don't, you can't get decent care for that person. So, without you knowing her life, it becomes more difficult for you to ask, how to approach it [gender issues] and have respect. If you are not respectful in your approach, you won't make it either, and many people run away and go look for another service, otherwise they end up being evasive and don't answer you. (E1)*

The encouragement of paternal participation during antenatal care was also perceived as necessary for the promotion of gender equity, as evidenced by the nurses' testimonies.

*The antenatal service also doesn't create strategies for this man to attend the consultation. If you do not create a strategy, she will go through the entire antenatal care without you getting to know the child's father, you don't get to know the partner, husband, boyfriend. So, it is also essential to include the man in this concept of antenatal care and also for the woman, to show her that the pregnancy belongs to both and not only her, the responsibilities are of both of them. (E4)*

*I try to encourage the man to participate in antenatal consultations. Some have even managed it, but others have not, even because of the matter of single mothers by choice. Sometimes, there is also the matter of opening hours and we have to prioritize the time that the parent or partner can be present. (E3)*

## Discussion

Despite advances in the social role of women, men are still seen as the main providers and decision makers in the family; and these conceptions can negatively influence women's access to maternal and child care services, especially in developing countries.<sup>10-11</sup> In this sense, social norms, combined with religious factors, contribute to low male involvement during pregnancy, childbirth and baby care, as well as to maintain female positions of opposition or restriction to the presence of men at these times, which has an impact on the effectiveness and an impact of health results.<sup>5,11</sup>

The testimonies of resident nurses expressed stereotyped ideas, since they pointed out fragility and maternity as key elements of female identity, while they referred to the strength and leadership position of men in the family and in society. However, they disagreed with such crystallized conceptions, which reflect the essentialist view built by a social order that naturalizes the male dominance; through which social norms, values and behaviors are guided by gender and power inequalities, including determining patterns of femininity and masculinity that are manifested in the structures and processes of social oppression and discrimination.<sup>4-5</sup>

As for inequalities, there is a crossing between gender and other factors of discrimination, marginalization and social exclusion, such as ethnicity, class, socioeconomic status, disability, age, geographic location, sexual orientation and sexual identity. This set of factors has complex effects on the health and well-being of individuals and the community.<sup>4-5</sup>

Gender-related socio-cultural barriers were also identified, which hinder the timely access of women to health care. In this regard, the partner's attitude may cause the woman to postpone decision making and the search for health services, due to financial dependence, reduced autonomy to make decisions and obligations to the family.<sup>4,12</sup>

Thus, despite the advances perceived by resident nurses regarding the participatory posture of some men, and although health policies encourage paternal involvement in antenatal

care, it appears that, in developing countries, there is still low male participation in pregnancy and childbirth due to social and health system's norms.<sup>9-10</sup> Furthermore, health units tend to have structured environments designed for women, such as maternity wards, which can make men feel uncomfortable in these places. In view of these factors, it is noted that gender norms influence male participation and the maintenance of traditional patterns of femininity and masculinity in the sphere of health and society.<sup>13-14</sup>

However, gender discrimination represents an obstacle to the quality of maternal health care. This problem requires the creation of effective strategies to deal with maltreatment in services, especially during childbirth; rights-based structure to promote them and give women a voice; clinical guidelines and national protocols with gender-sensitive and rights-based perspectives; and a monitoring system that encompasses gender indicators.<sup>12-13</sup> In this sense, there is evidence that partner involvement can positively impact the use of maternal and child health services, for example, can improve the use of health services by women and decrease the likelihood of complications in childbirth and maternal depression.<sup>11-12</sup>

A review study, carried out in developed and developing countries, found that male involvement brings benefits to maternal health: greater maternal access to antenatal and postnatal services; reduction of harmful maternal practices such as smoking; improvement in maternal mental health; increased likelihood of using contraceptives; and relief from stress, pain and anxiety during childbirth. In contrast, they highlighted disadvantages such as the increase in male dominance in decision-making and the potential to cause greater difficulty in labor due to paternal anxiety in the obstetric center. Thus, the meta-analysis concluded that male involvement is associated with better maternal health outcomes in developing countries, but pointed to a lack of robust studies on the topic in these countries.<sup>12</sup>

As for health programs aimed at stimulating male participation, it was found that programs without a focus on gender norms were insufficient to effect significant changes in

social relations in maternal health, as the results were modest and limited with regard to improvement of health indicators.<sup>13-14</sup> In this perspective, there is a complex relationship between gender and health equity that encompasses three interconnected domains: social determinants, health behaviors and health system responses. In addition, gender inequities are manifested in health systems and affect all areas of social life, such as education, health and work, especially for women, causing wage disparities, physical and sexual violence, restricted representation in leadership and decision-making, among other inequalities.<sup>5</sup>

In view of these limitations, the SDG, as already mentioned, seek to promote gender equality and combat the historically constructed inequalities between women and men. However, restrictive gender norms still compromise the health and well-being of communities and individuals, not just women, but also men and gender minorities.<sup>14-15</sup>

In the broader context of gender issues, resident nurses expressed the unpreparedness of services in providing adequate care to this clientele, despite the current trend for same-sex couples to increasingly access reproductive health services. Studies on the topic demonstrate that these people tend to receive less egalitarian care compared to heterosexuals.<sup>16-17</sup>

Women who declare themselves lesbian, gay, bisexual, transvestite, transsexual, or who identify with other forms of gender and sexuality (LGBT+), face rejection, disrespect, isolation and judgment that negatively affect their relationship and communication with health professionals. This social group is afraid to share their sexual orientation with professionals and experiences insensitivity, ignorance and biased treatment due to the organizational heterosexism of health services, which causes discrimination, intolerance and moral judgment in health care.<sup>17-18</sup>

An Israeli study revealed that most nurses who care for lesbian women, from planning their pregnancies to birth, did not receive specific training to understand the specific needs of the LGBT+ population, which encompass the process of building sexual identity and the role

played by each of the partners of the same sex in the conjugal relationship, the generating and raising of the children. Despite the changes observed in professional attitudes towards homosexuality, it was found that discrimination is still quite common.<sup>18</sup>

Another relevant aspect is that transgender men are designated as women at birth, but identify themselves as men. Although some undergo hormonal treatment and/or surgery that disadvantage pregnancy, many preserve the female reproductive organs and, consequently, their ability to become pregnant. However, despite the increased social visibility of transgender people, research on the topic is still limited, as well as the experiences of health professionals with transgender men who become pregnant.<sup>17-19</sup>

A study with transsexual men over 35 years old found that the reproductive desires of these individuals are similar to those of cisgenders, those whose gender identity corresponds to the gender assigned at birth. Some transgender men may also have highly desired pregnancies and others consider that pregnancy is necessary to start a family.<sup>17</sup>

Therefore, in a heteronormative world, health professionals may feel unprepared and uncomfortable in caring for LGBTTT+ people, which predisposes inequities in the health care of this population.<sup>16-18</sup> This lack of preparation signals that the gender theme needs to be adequately addressed in nursing education, as care must be guided by the ethical principles that guide the profession and the inalienable rights of the human person, which include sexual and reproductive rights.

On the other hand, transsexual men have unwanted pregnancies. Research with these men who experienced pregnancy and childbirth identified that about 30% of them did not wish to become pregnant. Most had their antenatal care accompanied by doctors, but also by obstetric nurses (28%), and delivered vaginally (64%) at the hospital, while a smaller portion had their birth at home (17%) and in birthing centers (5%).<sup>19</sup>

Faced with this emerging reality, it warns of the importance of debates about the experiences of the LGBTTT+ population in reproductive health and the rights that these people have to receive qualified health care that is appropriate to their gender issues.<sup>16,19</sup>

For the adequacy of antenatal care and obtaining better health results, resident nurses consider that the promotion of gender equity should stimulate female empowerment, as it enables greater personal capacity to make strategic choices in life in the face of a historical context in which this capacity is still denied. This stimulus allows women to increase self-confidence and affirm the right to make choices and gives them access to resources that can assist them in overcoming economic dependence and subordination.<sup>5,14</sup>

Given the above, it is clear that the health system needs to consider the impact of gender on the social and health status of the individual and the community. In addition, it needs to adopt good human rights practices to avoid the damage resulting from the reproduction of gender and power dynamics, such as those reported in assisting women and minority groups.<sup>5</sup>

Thus, it is expected that nurses are able to provide shelter, establish a relationship of trust and provide respectful and qualified care to people, families and communities.<sup>1</sup> Regarding antenatal care, in addition to aiming at maintaining physical and emotional well-being of the pregnant woman and the fetus, it is recommended that they promote health through information and guidance on pregnancy, childbirth and postpartum. They should also seek to stimulate female empowerment, in order to promote women's self-confidence in the exercise of their right to free choice, decision-making and autonomy, enabling them to experience these moments with protagonism and maternity in a full and pleasant way, with active partner participation and family support.<sup>1-2,7</sup>

Regarding the promotion of equity in antenatal care, despite the complexities related to gender issues, the proposals of the participating nurses list the professional attitudes necessary to care for women and partners, such as the ethical and welcoming professional posture,



stimulating female empowerment and increasing male participation in maternal care. However, they are proposals aimed at the individual care level of pregnant women and their partners, which do not encompass collective strategies integrated into the service's care process and its possible interfaces with the health system and other sectors of social life, although they recognize that there are limitations in addressing gender issues in the daily care of services.

However, reducing gender inequality involves structural or systemic challenges that go beyond understanding and gauging the effects of gender norms on the individual and his or her health. Thus, strategies that try to reduce this inequality must be diversified and intersectoral, including social participation, as well as actions that encourage empowerment together with health promotion. Only a systemic approach, at a micro and macro-social level, allows the values and attitudes of individuals and health experiences anchored in social and gender inequalities to be modified.<sup>20</sup>

In this perspective, the group of nurses in the study described here demonstrates recognizing the gender issues that emerge in antenatal consultations and their influences on maternal health. However, they affirm not being aware of everyday health-promoting experiences with a gender perspective in the services where professional qualification occurs, which may denote a possible persistence of the clinical focus on care.

It is noteworthy that the clinical approach is considered restricted in health and can be seen as consonant, consciously or unconsciously, with the current political and health context that limits the expanded and democratic projects in favor of public health, social participation, equity of gender and women's empowerment.<sup>8</sup> These limitations are challenges for teaching and the health and nursing care, requiring the academy and service to develop strategies to face gender inequities applied to the care practice in order to improve the effectiveness of their results.

Finally, the limits of the present study should be highlighted, since it analyzed the perceptions of a limited group of nurses who were qualifying in antenatal care in residency

programs; for this reason, its results should be considered with caution as they are not representative of the diversity of realities and perspectives of nurses in the scope of antenatal care.

## **Conclusion**

Nurses qualifying for antenatal care consider that female and male norms, values and behaviors towards maternity and paternity are determined by traditional gender roles, and that gender inequities give rise to situations of violence against women and the low male participation in the gestational period of their partners, suggesting that the study participants recognize the influence of gender issues in care.

Nurses also bring to light emerging issues in society, such as the increase in men with a participative posture in the care of their pregnant partner and the search for same-sex couples for antenatal care, and these couples still raise prejudices and disturbing situations for health professionals. Participants suggest that addressing gender issues should include female empowerment and male participation in maternal care; in addition, they mention the importance of the professional providing care with an ethical and welcoming attitude, but recognize limitations in this approach in the services where they are qualifying. The promotion of gender equity in antenatal care was conceived only at the individual level of care and not as part of health promotion actions in the service.

This restricted perception imposes on the academy and the service the need to work together to conceive, implement and evaluate intervention proposals that incorporate the gender perspective in antenatal care, favor the adherence of professionals and sensitize the clientele so that the relationship between gender and health is discussed, allowing improvements in health outcomes and advances in professional qualification in health and nursing.

It is hoped that the findings described here may contribute to the debate about the persistent and emerging challenges related to gender, as well as the necessary advances in

teaching, assistance and research on the theme of gender equity in health and nursing, gender approach in antenatal care and an expanded and non-binary gender perspective in reproductive health in PHC services.

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