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Articulating gender and health: professional qualification within the scope of Rede Cegonha

Articulando gênero e saúde: formação de profissionais no âmbito da Rede Cegonha

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Abstract

Educational demands from Rede Cegonha health teams at Metropolitan Region II of Rio de Janeiro inspired a University Extension Project with the goal of contributing to health care improvement. We present a critical and reflective description of this initiative, underscore its processuality and point out its challenges, limits, and potentialities. The approach to gender as a cross-sectional theme, the shared production of knowledge in the educational process pedagogical and the work in a health network have been particularly addressed in the pedagogical policy underlying this study. Based on participatory methodologies, five meetings were held, approaching the following themes in a theoretical and practical perspective: gender and sexuality; violence; feeding and nutrition; health care during pregnancy, at childbirth and until children are two years old. There were varied degrees of gender crossings in the personal and professional lives of the participants, most of whom were women: for example, from restrictions to their choice of education or career opportunities to the current situation in which women are the sole or primary breadwinners but experience inequalities in gendered division of labor. In health services provided to pregnant women, their partners and children, one could still see potentially discriminatory practices; inexperience/embarrassment when dealing with new marital arrangements; feeding myths; reluctance to allow the father's presence and participation. Women's autonomy and right to choice and information were recurrently neglected – from the moment of forced fasting when she is admitted to hospital until the moment a cesarean section is induced. Therefore, it was concluded that it is crucial to include

the theme of gender in health professional education and training programs, either at a specific point in time or throughout the whole program.

Keywords: Gender and Health. Patient Health Care Team. Maternal and Child Health Services. Education.

Resumo

Partindo-se de demandas de formação em saúde situadas no processo de trabalho das equipes multiprofissionais envolvidas na implementação da Rede Cegonha na Região Metropolitana II do Rio de Janeiro, realizou-se ação de extensão com objetivo de colaborar para melhoria do cuidado integral. Apresenta-se descrição crítica e reflexões sobre a ação, sublinhando sua processualidade e apontando dificuldades, limites e potencialidades. A abordagem de gênero como tema transversal no processo ensino-aprendizagem, a produção compartilhada de saberes e o trabalho em rede na saúde foram privilegiados na concepção político-pedagógica. Por meio de metodologias participativas, foram realizados cinco encontros teóricos e vivenciais sobre gênero e sexualidade; violências; alimentação e nutrição; cuidados na gestação, no parto e na criança até 2 anos. Em graus variados, foram observados e problematizados atravessamentos de gênero nas vidas pessoais e profissionais das participantes, em sua maioria mulheres, como restrições para estudarem e escolherem suas carreiras, chegando aos dias atuais em que as mesmas são chefes de família e vivenciam desigualdades na divisão sexual do trabalho. Nas rotinas praticadas junto às gestantes, puérperas, parceiros e crianças, percebeu-se a permanência de práticas potencialmente discriminatórias; inexperiência/embaraço para lidar com novos arranjos conjugais; mitos na alimentação; obstáculos para a presença e participação dos pais. A autonomia e o direito da mulher a escolhas e informações – desde a sua admissão, em que estar em jejum é regra, até a cesariana induzida – foram recorrentemente negligenciados. Conclui-se pela pertinência de inclusão, de modo pontual ou transversal, do tema gênero na formação profissional em saúde.

Palavras-chave: Gênero e Saúde. Equipe de Assistência ao Paciente. Assistência Materno-Infantil. Educação.

Context of the experience

The Rede Cegonha ("Stork Network", RC) is a strategy developed by Brazil's Ministry of Health to ensure women's right to reproductive life plan as well as humanized preconception health care, birth care and postnatal care, in addition to the child's right to safe birth and healthy growth/development.[1] In order to assist with implementation of the Rede Cegonha, the authors developed the university extension project entitled "Rede Cegonha: an interagency proposal for continuing education" at the Federal Fluminense University (UFF).

UFF, through the Instituto de Saúde Coletiva ("Public Health Institute"), is a member of the Comissão de Integração Ensino Serviço (CIES) ("Teaching-Service Integration Committee") of the Metropolitan Region II of Rio de Janeiro (CIES / Metro II), which consists of seven municipalities. This management committee enables interaction with the health service network, as well as partnership with coordinators of municipal Continuing Education Programs. Thus, since its inception, the workflow has been participatory, with the general purpose of offering a multitude of professionals with qualification and training opportunities for them to provide health care to women and children in *Rede Cegonha*.[1] Based on this perspective, the starting point of the debate consisted of actual work practices, as recommended by the *Política Nacional de Educação Permanente em Saúde* (PNEPS) ("National Continuing Health Education Policy").[2]

This endeavor has been primarily centered around gender. Introduced in academic studies in the 1970s, the term can be understood as the set of rules by which biological differences are transformed into social norms, and it has been used in various ways in analysis, research studies and public policies.[3-5] We have adopted the perspective of social and historical construction of gender, as introduced by Joan Scott (1995) as a constitutive element of social and power relations.[6] The author stressed that the term can produce hierarchical meanings and perceptions as far as sexual differences are concerned, which can further encourage the system of inequality between men and women. In addition, we seek to approach other dimensions of life (e.g., race, class, sexual orientation) which are considered to be inseparable and intertwined.[5]

In the field of public health, previous studies[7-9] have reported the impact of gender on health care and the influence of individual and/or institutional practices in strengthening or weakening inequities and asymmetries. The biomedical paradigm that underpins the hegemonic model of vocational training and health care practices historically favors the female body as a target for intervention and control.[10-13] In particular, it affects experiences of assisted human reproduction. As a result, men are excluded from this process and pregnant women, parturients and children[14] - as social actors involved in the *Rede Cegonha* Strategy - become more vulnerable.

Although the approach to gender is included in the guiding principles of *Rede Cegonha*, there are no specific descriptions of initiatives in this respect. Conversely, there is usually no clear

perception of gender crossings that underpin our personal and professional conduct on a daily basis. We therefore believe that it is crucial to promote reflection and debate about education and training in health care practices within the Rede Cegonha, because as gendered actions, they are potentially impactful. Therefore, this paper reports a critical description and some reflections about university extension initiatives. It also underscores their processual approach and points out difficulties, limits and potentialities.

Political and programmatic frameworks: limits and progress of the inclusion of a gender perspective in the processes of health care education and provision

In Brazil, the Programa Nacional de Atenção Integral à Saúde da Mulher (PAISM) ("National Comprehensive Women's Health Program"), set up in 1983,[15] broke paradigms relative to the principles and guidelines of women's health policies, thus paving the way for the perception that inequalities in gender relations can cause suffering, illness and death, especially among women.[16] Resulting from the struggle of social sectors, e.g. women's and health workers' movements, in an environment impregnated with the feminist slogan "Our bodies belong to us," PAISM has overcome the restrictive views of reproductivist welfare policies by adding comprehensive health care provision to all dimensions of the female universe, e.g. cancer, menopause, abortion, violence, to name a few.[7,17]

In addition, another aspect to be highlighted as innovative and powerful in the movement was to give voice and choice to women's discourse about their experiences with their body and their health, thus somehow rescuing their leadership and citizenship, and opening up possibilities of collective construction of knowledge as opposed to medical-scientific knowledge/power. Discussion groups were successful strategies, and they started being used as a health education methodology which was recommended and included in some health services. As a result, there was greater horizontal interaction between health workers and users, who became active subjects in health care practice.[18]

However, even if other covenants and policies have validated some of the guidelines of PAISM (which reached the status of National Comprehensive Women's Health Care Policy in 2004),[16] the approach to gender has not been properly addressed by professional education training and, as a consequence, by educative/health care practices, as originally advocated in women´s discussion groups.

In the realm of health and sexual and reproductive rights and their interaction with the actions proposed in *Rede Cegonha*, and considering the situation of extreme gender inequality as well as the high rates of maternal mortality, the initiative of the World Health Organization for promotion of Safe Maternity through Human Rights is extremely important.[19] In addition to providing high-quality services, one must recognize that cultural aspects (e.g., conditions in which gender relations are established in each individual country) can interfere in health care practices. For this reason,

it is essential to ensure access to information so that women can feel free to make decisions and choices about motherhood as well as experience motherhood - if they wish to do so - without any risks.[19] Such an initiative can help identify and assist women, children and families that suffer violence both at the interpersonal level - e.g. violence inflicted by intimate partners – and at the institutional level, for example, obstetric violence practiced by health professionals themselves. There are frequent reports and studies that describe the occurrence of violence during pregnancy, which is a very serious pattern of violence. It is possibly more frequent than diseases usually found during pre-natal care, such as diabetes and hypertension.[20-22]

In Brazil, women's rights in the context of pregnancy has been enhanced by Law No. 11.108/2005, which ensures a companion during the entire period of labor, delivery and postpartum care.[23] The Law also recommends strengthening the role of pregnant women, parturients**,** and newborn mothers and their children so that they can be protected against various types of abuse and/or negligence, in an attempt to deconstruct gender stereotypes which are traditionally reinforced by the prevalent biomedical health care model.

In turn, the National Comprehensive Men's Health Care Policy (PNAISH)[24] has reaffirmed that fatherhood is not only a legal obligation but also a right of men, which starts at the moment of deciding, together with their partner or spouse, when, how and how many children they will have. It should be noted, however, that attitudes supported in stereotyped notions about men often fend them off the process of health care provision.[25,26]

Even though Rede Cegonha assumes that women play a major role in the context of health care, it is not free of criticism or controversy. It has been criticized by feminist movements as a setback to women's comprehensive health care by limiting them to their reproductive function, because when the network considers a previously established pregnancy as the starting point for intervention, neither the conditions under which such pregnancy occurred nor the expectations of its evolution are taken into account. The assumption of maternity as an intrinsic element of feminine identity is not problematized, hence its socially determined character and its historicity are disregarded. When men and women are enclosed in their essentialist determinism of sex, the gendered dimension of motherhood and the care provided for this event.[27-29]

Therefore, the work process in the realm of health care, especially as regards the reproductive cycle, reveals limitations and reluctance in the performance of health workers, whose training, based on the biomedical model, restricts the possibilities of the protagonism of men and women. In addition, their personal and professional experiences reflect gender-related myths and prejudice, associated with maternity and paternity, which can negatively impact health care practices.[30]

Finally, it is worth pointing out that being pregnant, giving birth, being born and growing up healthily are conditions that usually involve two to three institutions whose professionals do not maintain a link with the expectant family, thus increasing the cost-benefit ratio of health

care provision and, at the same time, causing people who depend on the Unified Health System (SUS) to feel insecure. The establishment of a health care network linked to the *Rede Cegonha* must therefore be evaluated on a regular basis in order to ensure the effective, high-quality and dedicated health care.[31]

Methodological strategies: our choices, activities and tools

The project was outlined between April and December 2015, with the approval of the Pro-rectory of Extension of UFF and carried out at the Nursing School *Escola de Enfermagem Aurora de Afonso Costa*. The team, composed of six professors and six undergraduate students in the areas of Nursing, Nutrition, Health, Medicine, Psychology and Social Service, worked together in the phases of design, planning, implementation and evaluation. A total of 38 health workers and five municipal Coordinators of Continuing Education participated in this initiative.

The program was organized as a 40-hour course, taught in five face-to-face meetings, which covered the theoretical and practical aspects of the following topics: gender and sexuality; violence; food and nutrition; health care during pregnancy and at childbirth; and child growth and development.

We used playful, participatory and dynamic group-oriented techniques that facilitate the emergence and visibility of the proposed themes. We also used tools that enabled professionals to prepare, either individually and collectively, strategic planning activities as intervention proposals for improvement of health care in *Rede Cegonha*.

For purposes of this article, we highlighted and problematized some gender crossings in the work process that emerged during the course. We avoided usingthe gender category only descriptively; on the contrary, we sought to reflect on expressions of gender found in health workers" everyday practices.

Gender-related personal and professional experiences

To give visibility to the possible stereotypes and/or characteristics considered as masculine or feminine and to problematize the social construction of gender, the health workers were given badges as they arrived. Each person should write their name at the front and, at the back, two characteristics: one that they considered to be female and one, male.[a] Subsequently, to address

a Dynamics inspired by the model proposed in the book *O Faciltador* ("The Facilitator"), produced for an action research project, coordinated by the interinstitutional Centers of Gender and Health Studies of the ENSP/ Fiocruz and IESC / UFRJ in 1998.

the theme, these health workers reported such characteristics in the group. These characteristics were discussed and deconstructed in their classic polarities and oppositions: sweet, caregiving and careful, vain and patient women *versus* gross, determined, objective, breadwinning and loyal men.

With a view to facilitating more in-depth analysis of the subject, a brief oral presentation was made on conceptual and historical aspects of gender. This decision was made because we realize, when faced with the need to report gender crossings in situations experienced by the participants, both in their personal lives as professionals; either silence (maybe indicative of a certain lack of knowledge about theme?) or consideration of homosexual relationships alone. In other words, the term gender was remembered by health workers mainly when referring to behaviors that deviate from the usual social standards, and they were naturalized when they referred to social inequalities which were historically constructed for both men and women.

Later, the participants were asked to create a timeline, where they would describe situations in which gender was remarkable in their lives, either positively or negatively. Some sentences and testimonials were emblematic as regards the relational character which produces asymmetries of power. Theyreported abuse within the family itself, as well as various restrictions experienced by men and women when they made study and careers choices, including the current days in which they are parents/breadwinners and experience the inequalities in the sexual division of labor,[32]signaling what Giffin coined as a "gender transition".[22]

According to the author, in the context of neoliberal policies, unemployment and precarious work conditions foster what is recognized as a crisis of masculinity. Such crisis can be seen in the conflict between the massive entry of women into the labor market and the fall of the breadwinning man. It is an update of gender inequalities, because in addition to doing housework and providing care, tasks that have been traditionally associated and performed by women, women also have to assist in the household budget. However, when they take responsibility for the provision of income - a situation which has been ideologically celebrated as an achievement of modern women who gained their independence by means of paid work - they end up having double workload, a situation which is often disregarded.[22]

The records shared in the timeline exercise illustrate these and other modulations stemming from social pressures, based on unequal gender relations and their effects on the lives of women and men: "I gave up my career to raise my first child"; "Separation: Now, I am the man in the family, I am both the father and the mother"; "would have learned how to drive at 18 years old if Iwere a man"; "I feel pressured to get pregnant..."; "I decided that I didn't want to be a mother, even though I felt the pressure from family and society"; "I chose to become a nurse even though I was aware of the prejudice I might face in thiscareerbecause I'm a man!".

The phrases were evaluated and selected for the construction of a panelto stimulate reflection on the social construction of gender in more concrete form for all the course participants and also

to represent *feedback* on the activity performed. The panel was posted on the wall of the meeting room and remained there until the end of the extension course. Often, the panel was used in the debates to refer to the participants' personal and professional life experience with the purpose of disclosing the possible influences of gender relations over health care practices towards men, women and children in the context of *Rede Cegonha*.

The participants of the course also identified the role of gender (in most cases, restrictive) in the relations between the various professional categories, in particular, between doctors and nurses. Dramatization exercises experienced by the group showed gender tensions and disputes of power triggered by hierarchies present in teams, as shown in the words of a participant: "You are the chief nurse and I am a nursing technician, you are now my boss..." The other retorted: "This technician is sort ofcheeky, huh?", "technician is so nosy about everything". These quotes signals issues that have to be resolved and hierarchy-related conflicts that need to be addressed.

It is worth noting the small presence of doctors in the course, a recurring situation in training and continuing educational activities in general. Such a situation, in our view, negatively impacts the processes of discussion, since the usual submission to medical authority may be a factor that hampers the protagonism of women in the reproductive cycle and the workflow in a multiprofessional team.

Gender and multidisciplinary work on food and nutrition

The theme "nutrition in pregnancy, at childbirth and in childhood" revealed tensions in respect to the dynamics of the working process in *Rede Cegonha*. The discussion of the theme "nutritional assessment of pregnant women" showed that the health workers usually recognize its importance, which is justified by the association of dietary changes, mainly mothers' excess weight, with adverse outcomes during pregnancy. However, many of them reported that they did not record the weight gain curve of pregnant patients on a regular basis, because they saw this practice as aduty of nutritionists.

This issue seems to reflect the segmentation of labor established that started in basic health care, thus compromising the comprehensiveness of health care provision to pregnant women and children in the short, medium and long term.[20]It can also affect the hierarchical division of labor based on power relations in the dimensions of the fields of professional activity and gender, bearing in mind that in nutrition, as well as in nursing and social service, there is a predominance influx of women. The social medicalization process, whose development has increased since the last century, and the conformation of the so-called "scientific" motherhood enabled women to become professionals in these fields, which are deemed as an extension of their "natural" rolesas caregivers.[33] The education and training of nutritionists, at the beginning of the deployment of this career, have incorporated this concept; it was introduced as a specialization more culturally

appropriate to women and associated with women's household chores.[34] Thus, the fact that the routine nutritional assessment of pregnant women (which should be made by a multitude of health workers) lacks prestige, can signal the little importance given to this theme in the context of primary health care, and also reflect hierarchical sexual distribution of tasks within the team itself.

Although the participants were aware of the significance of the theme food and nutrition during the pregnancy, most of them only showed to be involved when the theme was associated with some morbidity. However, the literature reports that pregnant women need to follow a particular type of diet, because their food habits will have an impact on the health of their babies.[35] Therefore, there remains an essentialist view on the responsibility of women in providing care to their offspring.

It was noted that the health workers were committed to encouraging breastfeeding for children up to 2 years old. There was, however, no mention of conflicts between the guidelines provided and desires/resistance of the women assisted. The practices were shown to be guided by the naturalization of breastfeeding as an activity typical of the feminine essence, and there seemed to be disregard of personal and family arrangements, specificities of class and race and different subjectivities. These practices are in line with the biomedical model of education and training and the normative character of health policies. However, the analysis of Brecailo and Tamamini[13] on the relationship between the concrete experience of breastfeeding women and the institutional discourse on the theme, points to the need to discuss, in professional training, issues such as women's autonomy, as well as stimulate a politicized view of breastfeeding, in which, in our view, gender plays a central role.

Furthermore, we observed the presence of myths in the advice given about healthy complementary feeding and in the process of weaning. The discussions revealed and reinforced genders crossings ingrained in the notions that cooking, breastfeeding and weaning a child are tasks eminently performed by women and relative to their nature.[36,37] Historically, in the sexual division of labor,[32] these activities are seen as typical of women and assimilated by them; fathers are seen as responsible for the productive function while women, for the reproductive function (which lacks prestige). Although influenced by other categories such as race and class, the accomplishment of house chores and care provision are still considered, nowadays, as hegemonically belonging to women's domain.[38]

The participants reported that they found it challenging togive mothers and pregnant women advice on complementary feeding and that such women had difficulty following their advice. With preconceived ideas, the participants assumed that the reason lies in economic and cultural limitations of those women. However, they do not explore alternatives in their specific contexts of life, nor seek for possibilities of intra- or intersectoral support. In this scenario, we thought it was appropriate to introduce and discuss the *Dietary Guidelines for the Brazilian population*, released by the Ministry of Health in 2014 as a technical reference to be applied at the Unified Health System (SUS).

We also discussed with the group the conception that food choices result from the interaction between beliefs, taboos, cultural values, affordability to purchase food, valuational notions associated with particular foods, biological needs and demands of consumption.[37,39,40] It was concluded that problematization and flexibilization of feeding behavior are required in order to deconstruct the commonsensical notions of "eating right" and "eating wrong".[40]

About violations of rights and invisible, silenced or trivialized violence: "It is a matter of gender indeed!"

It was a difficult task to describe or determine how or where the issues of discrimination, violations and, ultimately, violence, were more prominent, since we observed crossing at several times in the education and training process that was gradually implemented.

Particularly, these were the activities that approached the theme of violence more directly: dramatization of a case in which there was suspicion of intimate partner violence; a debate about the perceptions and experiences of health workers; a videodebate with representatives of *Rede Cegonha* about the documentary *Violência Obstétrica: a voz das brasileiras (*"Obstetric violence: the voice of Brazilian women"*)*; and a situational survey about the networks of violence in seven municipalities. All of them, in some way, fostered what we call "constructed visibility"[21] of the most diverse types of negligence and "nameless pain"[41] which were experienced by women: in the case of pregnant women andnewborn mothers, in their intimate relationships and in health services (currently recognized as institutional violence). Some participants of the workshop, in addition to violence experienced in domestic and family relationships (which they reported during the group dynamics activity of the gender timeline) also suffered moral and sexual harassment in work relations, based on gender hierarchies.

When we asked the group the question "what is violence?" and "what violence do we experience?", we heard answers such as "privatization, devaluation of labor, deterioration and privatization of public health, criminalization of poverty and urban violence". These answers confirm that violence is not only a relational but also a structural problem in our society. Subsequently, one male participant gave the question "how is violence related to *Rede Cegonha*?" the following answer: "Poor service, pressure on mothers, not allowing women to make their own choices. Violence is also about not acknowledging or ignoring the fact that a person is suffering violence".

We know that intimate partner violence (IPV) in the domestic sphere can be a more frequent problem among pregnant women than many disorders diagnosed on a regular basis during the prenatal period.[42] Thus, we emphasize that when health workers do not understand or realize that there can be an association, for example, between the fact that a pregnant woman is suffering violence

and continues smoking and/or is not gaining weight, the quality of health care provision can be severely limited. Another example is newborn mothers who find it difficult to breastfeed their baby and might be in conjugal and/or family relationships in which conflict and aggression are recurrent.

As regards the procedures and resources needed or available for health care to women in situations of violence, what was most surprising was the biased restriction of some health workers to the provision of emergency contraceptives to women - a method that is approved, available and standardized by the Ministry of Health.[43] This situation, in line with the above-mentioned literature, showed how much it is still necessary to offer spaces for reflection and differentiated processes of education and training. These process should focus not only on protocols but also on subjective aspects relative to the perceptions and experiences of each member of health care teams, with respect to the gender relations and women's human rights.[44-46]

Finally, with respect to the major theme of obstetric violence, we highlight the account of a participant/doctor about the cesarean section his daughter went through because of the exclusive choice of a fellow doctor, which was decisive for the debate which was intended with the activity: "It is a gender issue, indeed. So far, only women can give birth". Such a problem-situation is the perfect example of how a woman's body continues to be the object of intervention and control, and women's knowledge is still undervalued, as compared to the power of doctors.[11]

In general, women's autonomy and right to choose and have access to information at all stages of health care - from admission to hospital (where fasting is rule) until the induction of cesarean section - were recurrently neglected in the practice of the multiprofessional team responsible for providing health care to pregnant women. At different levels, this behavior is a violation of rights and is deemed by such women as institutional violence, usually traversed by gender inequalities.[43]

Male caregiver

The sexual and reproductive rights of the child's father or the partner of the pregnant woman/mother are guaranteed, as one of the guiding principles of Rede Cegonha, and as highlighted in the National Comprehensive Men's Health Care Policy (PNAISH)[24]. The publication *Guia do Pré-Natal do Parceiro para Profissionais de Saúde* ("Men's Prenatal Guidelines for Health Workers"), released in 2016,[47] also states that this right should begin with the decision shared with the woman about when, how and how many children they will have, and such right should extend to following up the woman's pregnancy, childbirth, postpartum period and children's upbringing.

However, compliance with the recommendations is faced with institutional barriers which are related to the socio-cultural dimension of gender issues, e.g., the belief that sexual and reproductive health, pregnancy, childbirth, child health care, etc., are topics that men are hardly interested in.

The question "Can there be a male caregiver?" was answered positively by some participants, but even these ones acknowledged that they associate thistask much more often with women than with men. We also identified potentially discriminatory practices; trends of moral judgment; inexperience/embarrassment when dealing with new marital arrangements (e.g. same-sex couples), reluctance to accept the presence of fathers in the delivery and birth environment. These aspects have been mentioned in literature for a long while.[25] In the words of one participant, "We, as health workers, create these barriers ourselves...". There is evidence that the effective participation of male partners in pregnancy, childbirth, postpartum and puerperal periods, and children's upbringing has a positive impact on promoting the health of the mother-infant dyad, on the reduction of the rates of conjugal and gender-related violence and on the reduction of obstetric violence.[43]

Moreover, no statements were made about the inclusion of men/fathers in Basic Health Care after childbirth, which can indicate ignorance or gender discrimination.[26] Some health workers reported that in the municipalities where they work, the presence of men during delivery is still prohibited. This prohibition violates Law 11.108/2005,[23] which guarantees the right of parturient women to have a companion of their choice during labor, delivery and postpartum care.

All these examples show the close relationship between conceptions of gender and masculinities of the health team and their health care practices, which must be problematized and/or overcome in order to ensure satisfactory levels of health care as recommended by *Rede Cegonha*.

Gender and "knots" in the network

When we discussed the operationalization of activities and procedures in the network and philosophy of health care provision at the municipal level, the participants explained that in some municipalities, a network had been conceived, and sometimes even designed, but not experienced, however. As reasons, they mentioned obstacles arising from pacts; lack of enough human resources; little or not enough clarity about roles and regulation of bed occupancy; overlapping lines of action in the institutions. As a result, patients felt unassisted and had little trust in the service offered. This was an emblematic phrase of this situation: "Births with common risks ended up having high risks because health care procedures were discontinued and pregnant womenwent to several different health units/municipalities in search of direct, effective and remedial health care." This negligence suggests crystallization of gender inequalities in health care practices because it offers hierarchical meanings and perceptions that feed the health system, thus making women vulnerable.[12]

At the beginning of the course, the participants were asked to identify strengths and weaknesses in the sectors of the institutions where they worked, as well as their limits and possibilities, on a Grove spreadsheet.[48] We found little emphasis on cultural aspects in the situational diagnosis of the network, especially as regards the rare mention of men as one of the actors in the process of obstetric care. As regards sexual and reproductive health, the health workers still prefer to take

care of the female body andignorethe male body. It is important to broaden the promotion of equitable rights and full attention to health needs of both women and men.[25]

In the scenarios where PAISM emerged, there were movements for the redemocratization of Brazil and for the Sanitary Reform, as a major political force for the creation of SUS. Also, the participation of women's movement was very relevant. By contrast, in the scenario of the construction of Rede Cegonha, there was little or almost no collective process of planning, implementation and evaluation of procedures, as well as little participation of male and female users of the health network. These aspects may point to the verticalization of the process of deployment of the network in those municipalities and, hence, the health workers of this network may feel somewhat detached from the process.

Throughout the extension project, several managers, health workers, community agents and women reported their experiences with a view to broadening the reflection on reality. However, in most action plans, which were presented as a wrap-up exercise, we did not see the inclusion of the good practices we had discussed. We recognize, however, that there were innovative and workable proposals, e.g., forming partnerships to gather men in their workplaces as one of the strategies for inclusion of men in health care, which may have positive effects on *Rede Cegonha*. Such initiatives are permeated by the culture of gender, which sometimes limits the understanding that health professionals, and men themselves, are subjects with rights to health care.[26]

Final remarks

This experience showed that health workers have, to varying degrees, a perception about the presence of gender crossings in their personal lives and work practices within Rede Cegonha and about their potential negative impacts on health care provision. It has also confirmed the relevance of *ad hoc* or transversal inclusion of this theme in multiprofessional training and education initiatives in the field of health. The involvement of undergraduate students in this initiative proved to be suitable and useful, because this discussion does not occur on a regular basis in undergraduate programs in the field of health.

We realize that, so far, there have been few reflections and/or proper practices regarding most of the topics we have proposed and addressed. Thus, we recognize the contributions of our initiative in the qualification of the network in the Metropolitan Region II and in the multiprofessional training of health workers. Furthermore, we believe that this experience, by having fully problematized reality, has contributed to the process of analysis and feedback of the performance of health workers and/or health services. it has pointed out points of tension, challenges and possibilities for overcoming the obstacles and provide the full operationalization of Rede Cegonha in the municipalities that participated in this initiative.

It was found that these health workers need to be further encouraged to offer healthcare that can produce respect and open dialog between the different types of knowledge. This premise will require processes of education and work in the field of health, guided by the proposals of teaching-learning process that seek negotiation of knowledge and senses as well as the shared production of knowledge.

We hope that similar endeavors are undertaken, and we concluded that there is a need to strengthen continuing education initiatives for qualification of health professionals who work in *Rede Cegonha*. Also, regular evaluations should be made of the health care network. Furthermore, we hope that the best practices that these health workers had the opportunity to get acquainted with, can inspire them to improve their workflow and the obstetric care they offer.

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Municipal coordinators of Continuing Education Programs in the Metropolitan Region II of Rio de Janeiro.

Nursing school *Escola de Enfermagem Aurora Afonso Costa*, for offering its auditorium.

Undergraduate students from the Fluminense Federal University.

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