

Nurses practices to promote dignity, participation and empowerment of women in natural childbirth

Práticas de enfermeiras para promoção da dignificação, participação e autonomia de mulheres no parto normal

Prácticas de las enfermeras para la promoción de la dignidad, participación y autonomía de las mujeres en parto normal

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ABSTRACT

The aim of the study was to research care practices used by nurses in order to provide autonomy, dignity and participation by women during vaginal delivery. It was qualitative, descriptive and exploratory research which involved 30 women who had given birth. The study was performed at a Birth Center in Salvador, Bahia. To support the analysis the concept of autonomy was used. The practices enabling dignity were: warmth; the promotion of the presence of a companion and providing a proper environment for care. They also provided a sense of calm and confidence in women. To enable autonomy, the factors considered were: promotion of coercion-free personal relationships; facilitating access to information; and, fostering the active participation of women. Although the Center has advanced in its efforts to promote autonomy and the participation of the women it serves, more effort is required to fully achieve this goal.

Keywords: Nursing Care; Gender and Health; Women's Health; Natural Childbirth.

RESUMO

Objetivou-se conhecer as práticas de cuidado utilizadas por enfermeiras implicadas nos processos autonomia, dignificação e participação de mulheres durante o parto normal. Pesquisa qualitativa, de caráter exploratório descritivo, desenvolvida com 30 mulheres que tiveram o parto realizado em um Centro de Parto Normal de Salvador - BA. Para subsidiar a análise foi utilizado o conceito de autonomia. As práticas dignificantes foram: o acolhimento; a promoção da presença de acompanhante, bem como, de ambiente adequado para o cuidado; e a transmissão de calma e segurança às mulheres. Para o processo de autonomia destacaram-se a promoção de relações pessoais livres de coerção; e a facilitação no acesso às informações; não deixando de estimular a participação ativa das mesmas. Embora no Centro tenha havido um avanço na busca pela promoção da autonomia e participação das mulheres atendidas, necessita ainda de mais ações para atingir plenamente esse objetivo.

Palavras-chave: Cuidados de Enfermagem; Gênero e saúde; Saúde da mulher; Parto Normal.

RESUMEN

Conocer las prácticas de atención utilizadas por las enfermeras que participan en los procesos de autonomía, dignidad y participación de las mujeres durante el parto normal. Investigación cualitativa, de carácter exploratorio y descriptivo, desarrollada con 30 mujeres que realizaron parto normal en una maternidad en Salvador, Bahía. Para apoyar el análisis, se utilizó el concepto de autonomía. Las prácticas dignificantes fueron: la acogida; la presencia de un acompañante y de un ambiente adecuado para el cuidado; y la transmisión de calma y seguridad a las mujeres. En el proceso de autonomía, se destaca la promoción de relaciones personales libres de coerción; y la facilitación del acceso a la información; no dejando para estimular la participación activa de las mismas. A pesar del Centro de Parto Normal tener sufrido gran avance en la promoción de autonomía y participación de las mujeres, todavía necesita más esfuerzos para lograr plenamente este objetivo.

Palabras clave: Atención de Enfermería; Género y Salud; Salud de la Mujer; Parto Normal.

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INTRODUCTION

Late in the 1970s, women movements and other sections of society started criticizing the health model prevalent in Brazil, especially the impact of gender relations on women's health. They challenged the obstetric care model which was characterized by the institutionalization of delivery, was focused on medical interventions and the routine use of unnecessary and intrusive practices.

The quality of care for women during delivery became one of the main focal points of debate, culminating in the Conference on the Appropriate Technology for Delivery, held in 1985, in Fortaleza - CE. The final document of the event recommended reviewing the practices adopted during delivery, abolishing unnecessary interventions; avoiding hospitalization, and the adoption of strategies to promote women's autonomy and their participation in the process of giving birth¹.

It is worth mentioning the establishment of Natural Childbirth Centers (NCC) as an alternative to implement this new model of obstetric care. To foster the creation of those centers, the Ministry of Health referred to positive experiences in countries that provided autonomy to nurses in the natural childbirth setting, by following the World Health Organization recommendations.

The NCCs are institutions where obstetric nurses can contribute more fully to the process of autonomy for women which is characterized by the search for active participation by women during delivery, and by their own therapeutic decisions².

According to statements made by women who underwent both natural childbirth and caesarean section, the first method was preferred by them. This fact can be observed in the nurses' work. Many women said that they were not subject to humane treatment in the institutions where they gave birth where there was a lack of warmth during admission. In the maternity centers characterized by the biomedical model, nurses had little or no autonomy to provide full care to the women, as they would inevitably stumble upon the power relations existing in these institutions.

Considering that the natural childbirth centers were established to provide efficient care to women, and were aimed at ensuring that mothers had a core role in the delivery process, the question can be asked: which care practices provided by nurses in a Natural Childbirth Center incorporate the processes of autonomy, dignity and the participation of women?

Based on the problems highlighted, this survey was aimed at getting acquainted with the care practices employed by nurses engaged in providing autonomy, dignity and the participation of women in natural childbirth. Autonomy is defined as a process which involves the expression of preferences and decisions in a context free of embarrassment, coercion or pressure. This process demands the establishment of conditions associated with sociocultural factors³.

Moreover, autonomy is a core concept in gender relations. The concept was formulated by Scott⁴. According to her, gender is a social construction based on the differences perceived between the genders and consists of power relations between them.

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METHOD

This was an exploratory, descriptive and qualitative survey undertaken with women who gave birth in a Natural Childbirth Center (NCC) in the city of Salvador, state of Bahia. The center was established in August 2011, built with resources from donations and incentives by the Federal and State Governments. It was the first Natural Childbirth Center in Brazil launched by the *Rede Cegonha* program.

According to the survey in the register book of the institution, in the two first years of operation there were 806 deliveries from August 2011 to August 2013, of which nearly 60% were assisted by nurses and 40% by physicians. Thirty women were interviewed. According to the register book, an average of 26 deliveries were assisted by nurses in the institutions for the three months prior to data collection. Collection was concluded when a repetition of responses was observed.

Data were collected from October 2013 to January 2014, twice a week, on the Mondays and Thursdays of the month, since these were the days of neonatal revision or visits to the pediatrician, about one week after delivery. The decision of interviewing women during this period was made to avoid causing embarrassment to hospitalized women when talking about the services they received, which could lead to a bias in the survey. Moreover, they might have felt unwell due to the physical or mental stress caused by the delivery.

The participants were selected by the following inclusion criteria: being of 18 years old or more; having been assisted by a nurse during delivery; and have the clinical, physical and psychological conditions to be interviewed. For data collection, the survey employed techniques such as non-participating observation; consultation of the institution's documents; and a semi-structured interview format.

Following were the tools used: digital recorder; the NCC register book; and a script of the semi-structured interview. The interview script included, among other issues, the practices used during labor and delivery, and the experience of having had a nurse assist the delivery.

The register book was used on the data collection day. Knowing the names of the newborn mothers booked into the centers made it possible to check if their deliveries were assisted by a physician or nurse, and approach those who had recently given birth and met the inclusion criterion. The interviews were conducted in a private room, respecting the mothers' privacy and availability, using a digital recorder that allowed the full transcription of the content. The use of an audio recorder facilitated the codification process. "Codification is how you define what the data in analysis are about"⁵.

The analysis was comprised of four phases: data preparation; concept-based codification; code prioritization; and, interpretation⁵. Interviews were read several times, identifying the codes and trying to establish correlations between the different statements of the respondents, during the process of trying to develop explanations to support the general analysis of the statements. The analysis was performed based on the concept of autonomy².

Codification referred to the concepts of dignity, autonomy and participation. In this context, these three concepts represented the codes. To make the codification, interviews were transcribed and printed. In each topic of the interview script the statements were highlighted in different colors using color highlighters and the codes were annotated on the paper margin.

The coded excerpt was then separated in braces ({}), with the code described. In some situations the keywords or most repeated words were marked with a circle to facilitate the process of prioritization. By the end of codification, texts could be accessed more easily, exploring the thematic ideas and quickly finding examples of statements representative of the content to under analysis.

After pooling the codes, what was being coded was analyzed in the prioritization process, considering codes as categories, and prioritization as sub-categories. One advantage of prioritization is that it prevents doubling codes, as it enables easier visualization of repetitions⁵. Moreover, this process sorted data and allowed better visualization of correlations between codes.

Therefore, prioritization was made based on the "dignity" code, finding the following sub-categories: 1) warmth in the NCC, satisfactory and differentiated care; 2) proper care environment 3) technical competence of the nurse; 4) presence of a companion during labor and delivery, among others.

A new and more detailed prioritization process was performed for sub-categories. Regarding the first sub-category the highlights were sensitive hearing and respectful professional/user relations; regarding the second one: ventilation, physical infrastructure, ambience, privacy and aesthetic; for the third, information was gathered on the commitment, knowledge and confidence of the professionals; finally, the fourth sub-category was related to emotional support, comfort and confidence of the women.

Regarding the "autonomy and participation" codes, the following sub-categories were found: 1) coercion-free personal relations; 2) access to information; 3) active participation of women. For these two codes there was no need for a second prioritization, as the information gathered in the first prioritization process was enough to construe these concepts.

The research project was approved by the Research Ethics Committee at Nursing School Federal University of Bahia in accordance to the National Health Council Resolution N^o 466/2012. Prior to interviews, respondents received information and clarifications and signed the Free and Informed Consent Term. To preserve anonymity, women were identified by the first letter of codenames.

RESULTS AND DISCUSSION

The study showed that care practices employed by obstetric nurses in a NCC, in the process of conferring dignity, were: warmth; encouragement of the presence of a companion; promotion of an adequate care environment; and giving a sense of calm and confidence to women. The autonomy of women in labor was achieved through the promotion of coercion-free personal relations between professionals and users, and facilitation of access to information. In addition to dignity and autonomy, the women were encouraged to actively participate throughout the delivery event.

DIGNIFYING NURSING ACTIONS

This category refers to the dignity of nursing care and concerns the prevalence of the conditions required to develop pride, respect for self and others, and the increase of self-esteem in users². The delivery process is a moment in woman's life where she is vulnerable due to pains, physical discomfort, anxiety, doubts and expectations, which could lead her to express negative feelings that might jeopardize the delivery.

When providing care to women, obstetric nurses in a NCC should develop actions geared towards individualized, welcoming and efficient care in an environment enabling integral care practices.

Warmth

The NCCs were created to ensure women's dignity during delivery, and to exercise the principles of humane care, warmth, sensitive hearing and respectful relations between professionals and users.

Warmth demands a new attitude of "doing" in health, focusing on subjects involved in the process of promoting health; reorganization of health services based on the problems of working processes; structural changes in health service management;

and an attitude of listening and a commitment to meeting the health needs of users⁶.

In this process, evident in the statements of the following women who had just given birth, it is worth mentioning the use of communication using words of strength and incentive, as well as the interaction between obstetric nurse and the patient in an individualized care setting and the reference to clients by their names, as examples of providing dignified actions to the women by the nurses.

During the screening exam she [the nurse]: - look, I'll perform the screening exam on you... She doesn't just come and do it, you see? She talks to you... Everyone there really joining you. You feel welcomed, a true family (E: "C.").

She talked to me to relief the pain [...] She was always there, near me. Always talking, always encouraging me, you see? (E: "B.").

She also helped me a lot to have. She asked me to be calm... the words helped me a lot (E: "F.").

She [nurse] was helping me to push, encouraging me (E: "Simone").

Oh, she encouraged me (laughs): - "Come on" "Vanessa"! Push! And I telling her I could stand it no more, I could stand no more and she encouraging me (E: "V.").

These statements provide evidence of the communication process. Generally speaking, women were informed before nurses performed procedures. "C.'s" statement reflects that when she mentions that the nurse informed her about the vaginal examination and what she would do before she did it. She did not just "come and did it".

Dialogue is part of a caring relationship and should not be used only to pass on information; rather it should be a caring act⁷. This is reflected in the well-being of the parturient women for whom, according to their statements, talking was a strategy to relieve pain and calmed them down. Calling them by their names directed the care to their specific needs, making them feel appreciated and confident to cope with hard moments.

The incentive for nurses for women to be strong and not lose heart in the face of difficulties should also be considered. In the statement below it is seen that dialogue has gone far beyond the biological health determinants, also taking into consideration the woman's emotional and psychological fields.

Then she [nurse] asked why I was crying and I said it was because my husband was not there, I thought he would make time for it, but he couldn't [...] (E: "T.").

This respondent was evaluated in a comprehensive way, not only was her physical condition observed, but also her sadness and feelings. Integrative care tries to value the multi-dimensionality of subjects, and could be considered to be an indicator of quality⁸.

Humane care should lead to individual care for women. In a setting of humane care one listens to the parturient women's complaints, trying to identify their needs, never disregarding their histories and social, psychological and emotional aspects⁹. Women should be welcomed and regarded as beings with needs that go beyond the biological field.

Promote the presence of a companion

The companion is crucial in providing emotional support. He or she provides women with comfort and confidence during labor and delivery, and could also provide benefits to them⁹. Feeling safe, their anxieties and fears are reduced. Therefore, denying the presence of a companion violates not only the woman's right to freely decide if she wants a person to accompany her, but also violates her right to citizenship⁷.

The companion can participate in the entire childbirth process, and must get the required guidance to behave in the best way possible for the woman's benefit. Nurses can provide companions with guidance on the use of massage, breathing exercises, dialogue and incentive to walk.

She taught my husband to do the massage. [...] she [the nurse] taught the massage movement, from bottom to top, until where I was feeling the pain. In my case, it was from the middle of my back down (E: "J.").

She [the nurse] guided all processes... taking a shower, relaxing, the massage my husband did (E: "S.").

The trained companion should provide information to the parturient woman about the evolution of labor, guidance on the most comfortable position to take and pass on information about the required interventions and procedures, facilitating the woman's participation in the decision-making process¹⁰.

The NCC nurses should continue to promote the participation of a companion, mainly the husband or partner. It is important to deconstruct the gender bias that women are exclusively responsible for reproduction and for taking care of children.

Promote adequate care environment

Many factors can influence the environment to make it adequate: lighting, hygiene, local temperature, ventilation, silence, privacy, physical infrastructure, furniture preservation, among others. The physical environment and the support of professionals are an integral part of care practice.

A survey has provided evidence that cleanness and ventilation were more important than physical structure and, due to their routine, many professionals disregard these details¹¹. In another study carried out in a hospital, women said that they were welcomed, but most of them were unsatisfied with the physical structure and lack of privacy in the institution, which did not make them feel comfortable¹². The respondents pointed out their perceptions about the NCC environment, as reported below:

Everyone is polite, everything is clean, organized (E: "S").

I got here and the place is really wonderful. You feel comfortable (E: "M").

You can have it on the rocking chair, squatting, in the bathtub, wherever you want. The room is adjusted for that (E: "J").

It was my decision, because there [a maternity] was under reconstruction and I found here more beautiful (laughs) (E: "R").

The environment can influence the performance of practices as highlighted by "J.". In sites equipped for vertical delivery, in a bathtub, obstetric bench and rocking chair, for example, the woman can decide the position she wants to take. Traditional hospitals do not provide these means to women, and most deliveries are horizontal, with no other option.

According to the respondent "R.", the aesthetic environment also influences the decision about the institution. The health team should create a tranquil and supportive environment, providing physical and emotional comfort and facilitate close contact between mother and baby, as soon as possible¹⁰. That is why it is important to equip delivery centers with standards that allow pre-partum, delivery and post-partum care in the same place, keeping the child always near the mother and favoring the well-being of both. A woman who has recently given birth should be able to rely on a cozy environment, with privacy that favors her active participation in care practices while valuing her autonomy in the decision-making process.

Providing a sense of calm and confidence in women

Surveys have confirmed that an obstetric nurse should be a committed and skilled professional who provides dignity, confidence and autonomy, rescuing delivery from being just a physiological event¹³. The more these professionals are updated through training courses, the better their development. To provide care, nurses should know about practices and interventions used, as well as about the potential impact of these procedures on women, paying special attention to the likely harmful effects.

When professionals deliver care to a parturient woman, they should build a relationship of trust to calm her and strengthen positive feelings¹⁴. To build this relationship the professional must disclose, through providing information, the best conduct recommended in each case, always individualizing the care provided not only to the pregnant woman, but also to the family and companions.

The women participating in this study noted the nurses' technical competence. Their professionalism had a positive influence on the birthing process, because the women recognized the dignity of the nurses' actions. These actions were illustrated in the following statements:

[...] she [the nurse] was very calm, she made me feel confident that she really knew what she was doing, lots of professionalism (E: "Samanta").

I was extremely calm because she [the nurse] made me feel confident (E: "F").

I didn't feel uncertain at any time (E: "C").

On the "potty" (obstetric bench) the nurse said I could accelerate, and there I went. It took less than 10 minutes. In fact I wanted to give birth in bed, but she said the potty was faster, and there I went (E: "R").

However, humane caregiving goes beyond employing mere techniques of care. It also comprises changing the technician care culture⁷. Care should be based on scientific evidence, with proven benefits for women.

The respondent "R." said the nurse recommended vertical delivery using an obstetric bench, as in this position gravity works more easily and expulsion takes less time¹⁵. When providing care to women, nurses should seek means to make parturient women feel confident to give birth, and to trust in the conduct being implemented.

WOMEN'S AUTONOMY AND PARTICIPATION

This category refers to autonomy of relationship between users and health care services and with users themselves in such a way that a change in the power dynamics in these relationships is possible. Participation, refers to the means through which women can work jointly with the nurse on nursing care, co-managing their interests².

When considering obstetric care which is focused on women's needs, their right to autonomy, access to quality information, and active participation in the delivery process should not be disregarded. These factors, used comprehensively by the health team to provide care to women, promote their empowerment. They start perceiving delivery not only as a natural and physiological process, but as a conscious and participatory one.

The following actions illustrate the concepts of women's autonomy and participation, enacted by the obstetric nurses in the NCC, as reported by the respondents.

Promotion of coercion-free personal relations

The relations between professionals and users must be free of coercion to preserve the woman's autonomy. Care should be provided less authoritatively so that women can make free decisions, without fear of prejudice or labeling by the health team. Their desire is to be free to negotiate the care they receive without feeling threatened by professional authoritarianism¹⁶.

In the NCC, according to the statements below, women could freely express their opinion, without fearing the nurses' judgment. Regardless of the fact whether the conduct suggested by the professionals was beneficial or not, women expressed their views, as well as the needs and difficulties they felt at the moment. They could either accept the actions recommended, or reject them if the professionals failed to give a convincing explanation or if the benefits did not outweigh the difficulties posed.

It was like this, the nurse suggested, she said: - don't you want to squat down? I said I will not endure it. But then it was better (E: "S").

It was because I asked to sit down, but as I couldn't get up I stayed in that position [semi-sat] (E: "T").

S." said that it was suggested that she squat down for a vertical delivery, she resisted at first but she was later convinced and decided to accept it. On the other hand, "T." was also advised to change position during delivery, however, due to the physical discomfort caused by pain, she decided to stay in the same position. In her situation, despite all the benefits of sitting down, the difficulties posed by the position led her to reject the conduct suggested by the nurse. In both situations the women's right to decide was respected and they made decisions with autonomy.

The nurses, in turn, provided options for the parturient women to freely decide what would be more convenient or comfortable to promote their well-being. It was not a matter of accepting or rejecting conduct, but a matter of acting according to their needs, free of impositions or coercion.

First the nurse asked me what I wanted. I said I preferred on the ball, and [she] had told me it was good. Then she said: - you prefer on the ball in the shower or out here? I prefer in the shower, because I take my bath. I stayed there for one hour (E: "T").

She, the nurse, kept telling me to test, to check the best position for me. And I went on changing (E: "M").

In another survey, the use of practices and attitudes were considered to be beneficial for women, according to whom their inner potential was strengthened when they made their own decisions⁹. Care for women should be a shared experience, giving them the opportunity to select the best actions for them, while encouraging them to follow good practices.

Enable access to information

Information is a crucial factor in ensuring autonomy to women and to help them make conscious decisions. Access to information empowers women. Empowerment is an educational process focused on health services users to help them develop knowledge, attitudes, skills and the self-knowledge required to effectively take on the responsibility about making the decisions affecting their health¹⁷.

The statement below shows that this woman received instructions that facilitated the making of her decisions.

In the room, I got guidance, took a bath for the time I wanted to stay. I could select the place where I would give birth, because there are many options (E: "J").

It is worth highlighting that guidance should be provided with confidence so that both the parturient woman and the companion understand it¹⁴. Moreover, women should provide feedback to the health team, so that the team can check if they have understood the information or guidance provided.

Communication through open dialogue and active listening is crucial in transforming health education into a critical and autonomous awareness-building process¹⁷. As aforementioned, communication is part of the practice of providing warmth and dignity to the women. When dialogue is capable of promoting confidence among women, they associate it with the good care received from health professionals. According to statements:

Then she [nurse] taught everything and always coming here, to the room, always asking if I was feeling something, if I was getting better, observing and caring; it was really good here (E: "J").

I talked to the nurse who was monitoring my delivery, asked her, clarified all my doubts... (E: "R").

"Empowerment comprises radical change on processes and structures that reduce the subordinated position of women as gender"¹⁸. Clarifying the women's doubts, providing them proper information and building confidence gives rise to more harmonious relationships and the possibility of making more autonomous decisions, giving them a core role in the delivery process.

Foster the active participation of women

The autonomy of women during delivery demands their active participation in the whole process of giving birth, respecting their rights of citizenship and reception of care based on scientific evidence. The parturient woman feels safer and more confident when she has the possibility of participating in the practices and procedures involved in delivery¹¹.

The active participation of women underscores the need for previously informing them about the practices to be used, and the health team should encourage their participation. To that end, women should be encouraged to be active participants in the process of giving birth.

If women's participation is to prove beneficial to them, the health team should present possibilities of practices based on some scientific ground. This will prevent them from being nothing but "piece workers" carrying out activities with no positive impact on the labor and delivery process.

The following statements emphasize that nurses, when inviting pregnant women to participate in some practices, should inform them about why they are suggesting it, rather than just ordering the practices with no factual grounds or based on their own expectations:

It was nurse [x] who decided for the rocking chair, also because it was more comfortable. I was watching TV and she brought the rocking chair (E: "I").

Then came a nurse and asked if I wanted to sit on the bench to relax... I sat down and it was the best position for me (E: "P").

They asked me to do. First, walking to start dilating, then she told me to do some exercises on the ball and on the rocking chair (E: "S:").

The NCC nurses promoted women's participation in comfortable practices by encouraging the use of the rocking chair and obstetric bench, and also promoted their well-being, as these actions were more comfortable and relaxing. These practices could also be used as non-pharmacological therapies to relieve pain, and are strongly encouraged by the Ministry of Health and WHO. Knowledge must inform the behaviors recommended to promote women's participation.

On the other hand, the statements made by those women who had just given birth showed that in a few situations, the actions by some professionals ended up moving the woman away from the longed for core role in the delivery process. Many times, the rigid attitude of the health team members focused only on the biomedical model. Technicality impairs professionals from the ability to make critical reflections in

order to find what would be better for the women. This attitude may prevent them from asking the women's opinions regarding the practices or interventions.

The following statements provide evidence of this kind of care provided to two women who had no autonomy to decide when to start breastfeeding the newborn. They were in a dilemma: whether to stay quiet and feel the pain of the suture and breastfeed at the same time, or despair and refuse to breastfeed until the healing of the suture.

I wanted to wait a little more, end the suture... because everything happened at the same time, so it is quite uncomfortable because it hurts (E: "M:").

They wanted to give me the baby for me to breastfeed her, but I was so despaired I was dead-scared of the suture, then I made a scandal in this maternity. [...] Then I said, no, for God sake, later, not now! (E: "Y:").

The statements made by the respondent make clear that a nurse sutured "M.'s" tears. This woman was giving birth for the second time, had experience of a previous delivery, and decided to keep quiet despite the pain she was feeling. Many women hardly take on a participatory role due to the culture of subordination in which they have always lived⁹. Women must develop awareness to fight for their rights and claim better care.

Regarding "Y:" it could not be identified who sutured her, whether it was a doctor or a nurse. It was known that the delivery was assisted by a nurse but in the NCC interventions are not always performed by the same professional. Regardless of the provider's identity, it was the first delivery for the woman and, thus, she had no previous experience with perineal suture. This experience may entail negative consequences for any potential future delivery experience, due to the memories of the suffering undergone during the first one. These situations illustrate inhumane care and the absence of behavior that maintained the patient's dignity and also show the lack of communication with the women. Neither the autonomy nor participation of these women was encouraged. The WHO recommends breastfeeding in the first hour of birth¹, but we can infer this practice was imposed as the women's opinions were not regarded. The violence and invasion against areas of the woman's body reveal authoritarian attitudes by health professionals.

When guided by gender indicators, nursing care unveils an authoritarian, unconcerned and decontextualized attitude regarding care for women, which goes against their rights as citizens². The use of care practices towards women by obstetric nurses in the NCC, whether positively or negatively used, disclosed the existing inequalities in the nurse-user relations.

FINAL CONSIDERATIONS

The study showed that the use of the concepts of dignity, autonomy and participation was a useful resource in gauging the care practices provided by obstetric nurses to women in the NCC. Moreover, it revealed a kind of care that valued integrative actions and focused on the users' needs. Despite the references to autonomy and participation, the practices conferring dignity were outstanding, maybe because these were more noticeable for women who, thus, reported it more frequently. Dignity is considered to be a basic element that should inform all health services, so that women can receive care in a proper and welcoming environment, with the use of efficient and acceptable practices. Acts of dignity were mainly concerned with the health service itself.

On the other hand, the NCC studied should progress with regards to the means of promoting women's core role and empowerment through nursing care favorable to their autonomy and active participation. This promotion is considered to be a key and differential element in health services.

The support provided by nurses during labor has dignified nursing care and shown that their work in the NCC must be studied since in these centers they have more autonomy to work.

It is also worth highlighting that the use of these concepts have disclosed a worrying situation. It was observed that, in a few situations, evidence-based practices were valued, but nonetheless, did not reveal either a critical consciousness by the professionals involved or the common sense to observe the right moment to use those practices. In those situations, professionals did not consider the women's opinions or their right to decide.

Therefore, for nurses to keep on providing quality care, the gender bias must be deconstructed. That bias places women in an inferior position in the existing relations between professionals and users. This is a biological determinant that prevents them from making conscious decisions and from having control over their bodies. The impact of gender issues on health must be considered in order to develop autonomy processes for women.

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