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Interactions between home care and hospital care during pregnancy and postpartum among low-income women in a maternity clinic in Cartagena, Colombia☆

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ABSTRACT

Introduction: This paper proposes an approach to maternal health from the care process perspective to understand how determinants of health manifest in the daily experience of women.

Objective: To describe and analyze the interaction between the domestic and clinical care during pregnancy and post-partum among women who live in adverse socio-economic conditions.

Methodology: Qualitative study based on semi-structured and in-depth interviews, participant observation, and analysis of secondary sources. Twenty women who received care at a maternity clinic in the city of Cartagena, Colombia were interviewed. Participants had an average age of 25, lived in adverse socio-economic conditions and had at least one of the following obstetric risks: preterm labor symptoms, previous abortions, or mild preeclampsia. Participant observation took place at the clinic and at the residence of four patients. In addition, six in-depth interviews were conducted with health workers of the clinic.

Results: The socio-economic conditions of women and their family dynamics determine their experiences of maternity. Relatives, usually other women, are the main agents of care. The most important care activities revolve around physical activities, transportation, nutrition, and exposure to the environment. The characteristics of domestic care play an important role in the clinical environment.

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Conclusion: Family-centered care requires acknowledging the role of relatives and other members of the women's social networks as guides in the healthcare process. Likewise, recognizing the socio-economic conditions of women requires adapting health services to the needs of women and their families in order to avoid reproducing social inequalities.

Interacciones entre el cuidado doméstico y hospitalario durante la gestación y el puerperio entre mujeres que viven en condiciones socio-económicas adversas que asisten a una clínica de maternidad en Cartagena, Colombia

Palabras clave:
Género y salud
Medicina familiar y comunitaria
Embarazo abdominal
Cultura
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RESUMEN

Introducción: Este estudio aborda la salud materna desde el enfoque del proceso de cuidado a fin de entender cómo los determinantes de la salud se expresan en la experiencia cotidiana de las mujeres.

Objetivo: Describir y analizar la interacción entre el cuidado doméstico y el cuidado hospitalario durante la gestación y puerperio en mujeres gestantes que viven en condiciones socio-económicas adversas.

Materiales y métodos: Estudio cualitativo basado en entrevistas, observación participante y análisis de fuentes secundarias. Participaron 20 mujeres que asistieron a una clínica de maternidad en la ciudad de Cartagena en el 2013. Las participantes tenían una edad media de 25 años, vivían en condiciones socio-económicas desfavorables y contaban con uno o más de los siguientes riesgos obstétricos: amenaza de parto prematuro, antecedentes de aborto y/o pre-eclampsia leve. Se realizaron observaciones en el hospital y en la residencia de cuatro mujeres. Adicionalmente, se entrevistaron 6 profesionales de salud de la clínica.

Resultados: Las condiciones socio-económicas adversas que reportaron las mujeres y las dinámicas familiares de su contexto determinan sus vivencias de maternidad. Las familiares son las principales agentes de cuidado. Los cuidados más importantes están relacionadas con actividades físicas, transporte, alimentación y exposición al ambiente. Los cuidados domésticos se trasladan al ambiente hospitalario.

Conclusión: Los modelos de atención hospitalarios deben reconocer el rol de las redes de apoyo de las mujeres como guiadores del proceso de cuidado y entender las condiciones de vida de las mujeres para adaptar los servicios a las necesidades de las pacientes y evitar reproducir situaciones de desigualdad.

Introduction

Maternal health is one of the major concerns for women's health at a global level and an indicator of societies' development in terms of the quality of health care services, living conditions, and gender equity. The majority of recent maternal morbi-mortality analysis models recognize that maternal health is multidimensional and requires interdisciplinary approaches.[1] These models identify three kinds of determiners: direct (obstetric risks, diseases, and diet), underlying (education, access to maternity services, health practices and seeking out care, food access, water access, sanitation and basic health services), and basic (political, economic, cultural, religious, social and health systems).[2]

This study approaches maternal health from the perspective of the care process, in an effort to understand how these determiners express themselves in women's everyday experience. We start with the idea of care as an intersubjective process inscribed in a particular socio-economic context and molded in the interaction of multiple spheres of care (home, biomedical, traditional medicine, etc.). From the health sciences, different authors have studied non-biomedical care and knowledge related to gestation through approaches such as knowledge, attitudes, and practices[3] and the approach of cultural care.[4] From the social sciences, reproductive health has been a privileged theme for understanding medicalization exercises on women's bodies[5,6] and the power and gender relations in community scenarios and clinical spaces.[7–10]

All these analyses have been highly illuminating. Nevertheless, the large majority of them tend to focus on one of the spheres of care. Analyzing the interaction between the different care relationships leads to a comprehensive understanding of maternal health, allows for the identification of

strengths and weaknesses of care, and offers keys for the development of care models that recognize the role of the different spheres and care agents in daily dynamics and the hospital space. The objective of this study, therefore, was to describe and analyze the interaction between home care and hospital care during the pregnancy and postpartum of pregnant women that live in adverse socio-economic conditions and are cared for in a maternity clinic in the city of Cartagena, Colombia. This study describes the experience of pregnancy as a process molded by the social conditions of the women and their families and formed in relation with others (both male and female) that participate in the care. This process is related to structures of social order that have to do with gender, race/ethnic, employment, and territorial dynamics that color each experience with particular specificities and itineraries.

The hospital in which this study was carried out serves women from Cartagena and nearby rural areas. Cartagena, with an estimated population of 1,001,755 inhabitants in 2015, has been described as one of the cities with most inequality in the country.[11] 26.6% of the population lives below the poverty line and 4.3% live below the destitution line.[11] Despite being one of the most touristic cities in the country, unemployment, informal employment, violence, and prostitution rates are among the highest in the country.[12]

Materials and methods

A qualitative, descriptive and interpretative study,[13] based on the subjects' experiences.[14] The information collection and analysis sought to characterize the perspectives and day-to-day life of the participants through abductive-iterative-recursive logic,[15] which refers to the possibility of reevaluating concepts in the interaction with subjects while being alert to signs and routes of interpretation and to adopting elements from different sources in order to reconstruct their realities.

Participants

20 women, with characteristics that represented the population served in the clinic, were selected through purposive, non-probabilistic sampling. Ten women in their first trimester of pregnancy, and ten women in the first week of the postpartum period were interviewed. The average age was 25 years. All of the women had been classified under population in conditions of poverty, twelve lived in marginal neighborhoods or rural areas, and eight lived in nearby municipalities. All presented one or more of the following obstetric risks: risk of premature labor, precedent of abortion and/or mild pre-eclampsia. These risk factors were suggested by the clinic's health professionals, since the patients interact frequently with the clinic and it is more feasible to locate them. Women younger than 18 years of age were excluded, along with those not classified as population in conditions of poverty, those not interested in participating in the study, and or those who did not agree to sign the informed consent form.

In additions, in-depth interviews were conducted with six professionals in the clinic: three nursing, two medical, and one dental professional. The participation of these health professionals enriched the narratives of the patients and the understanding of the clinical space.

Instruments

The information was collected through in-depth and semi-structured interviews, records in a field journal of days of participant observation in the clinic and in the residences of four of the patients, and analysis of secondary sources. The central categories of all of the information collection instruments were: living conditions, care in the domestic sphere, and experience during the hospital stay.

The use of multiple research methods and sources and the review of information by four researchers permitted the validation of the information collection and the data analysis through triangulation.[16] The number of participants was defined in accordance with the saturation point; that is, once the participants no longer contributed significantly new information to the categories that were already revealed.

The information was classified in thematic and emerging categories with the quantitative analysis tool NVivo 10. The researchers contrasted the emerging categories with the initial theoretical categories and established analytical axes that allowed for the formation of a narrative thread for the results.

Results

Characterization of the women's realities

Even when each woman has a particular life path, those who participated in this study coincided in the following: a short schooling time; few formal employment opportunities and no employment possibilities during pregnancy; and precarious housing conditions. The majority of them had limited access to transportation and health services, particularly potable water. Four reported gender violence in their family and/or with their partners. Another essential characteristic of the reality of these women is multiparity and multiple parents. All considered that three was the minimum number of children —"fewer than three is not a family"— and, with only one exception, those with more than three children had conceived them with different partners.

> *"There are people that already made the decision to have their tubes tied... and after... the want them undone because now they live with a guy who doesn't have kids... and... they have to give him one, otherwise he'll go look for another woman". (Professional 2)*

Men seek to demonstrate their active heterosexuality through procreation and strengthen their virility by taking on the responsibility of supporting his partner and the children with her. Nevertheless, this role as provider ends when he or she ends the sentimental relationship. For women, conceiving several children is related with a social imperative of maternity and with a palliative escape from economic vulnerability that they permanently face. The families form and re-form, upsetting the imaginary of the stable nuclear family. A knowledge of these diverse family configurations is necessary to avoid a passive attitude in the face of structural

violence experienced by women and the furthering of sexist stereotypes by which they are judged for their active sexuality.

Changes in daily activities

Despite the fact that the women reported that the daily life of the family was not radically reorganized with every new pregnancy, there are some special considerations with regard to mobility, physical activity, and exposure to the environment that affect both domestic and hospital care. In terms of mobility, the women avoid using available means of transportation such as motorcycles and busses due to the lack of comfort in these vehicles and the precariousness of the roads. This restriction is worse for women that live in rural areas or neighborhoods far from the clinic. These difficulties affect attendance of prenatal check-ups, as well as the possibility of arriving at a health center in a timely fashion in the case of an emergency.

> *"To go to the check-ups, the bus left me pretty far away from the health post and they wouldn't accept me in the moto-taxi being pregnant and with the baby... they wouldn't take me like that" (M152013).*

Whenever possible, the women attempt to reduce daily physical activities with the help of their mothers, mothers-in-law, sisters, and, on certain occasions, their partners. The days of participant observation made evident that the assistance that the women receive in their domestic units is similar to the assistance they receive in the hospital environment from their companions, who alert them about certain postures, make sure they do not lift heavy objects, and prevent risks of falls.

Another important preventative measure is the exposure to the environment: to not go out late and not expose oneself to the moon or the sun. This is related to a precaution surrounding "the cold", associated with pains and body discomfort, and "the heat", which could act as a labor-inducer. These notions are not only related to the environmental temperature but also to certain foods and activities, as well as the properties of the moon, the sun, the wind, and the plants. In Cartagena, unlike in the interior of the country,[17] there is a particular aversion to things considered "hot".

> *"I always cooked... But there were times that they didn't let me get too hot in the kitchen... they said... "¡No! ¡Get out of the kitchen!" My mom cooked for me... in the morning though... I cooked a little... and at midday my husband's mother would come to the house..." (M012013)*

> *"My grandma doesn't let me go out in the hot sun. The hot sun is bad" (M022013)*

Respect for these kinds of conceptions about the body and wellness proved to be an essential element for the women when it came to accepting recommendations from health professionals.

Food

The pregnant women barely change their diet to include recommendations like fruit and vegetables, not because they are unaware of their properties but because they are not usual foods in their homes, and, due to a lack of resources, it is difficult for households to reorganize around the nutritional needs of a single family member

> *"... yes, I had to lower the salt a bit... the fat... and so on... More fruit... more vegetables... if we could... because it also depends on money..." (M082013)*

> *"We eat like poor people, we can't be worrying about what we eat and what we don't eat. Whatever there is; that's what we eat". (M032013)*

> *"In the village... we eat things that they grow there for breakfast... like yucca, plantain... that's what I eat" (M022013)*

Nevertheless, there are some foods that the women include or restrict based on family recommendations. They include or increase the consumption of internal organs, the liver, the spleen, and grains, as well as juices of red fruits and vegetables like blackberries, beets, and especially *agraz* (Andean blueberry, *Vaccinium meridionale)* because they are considered useful for increasing hemoglobin and fighting anemia. They also consume shakes and juices made with seeds like sesame and purging cassia.

> *"They made me drink some beet juice... [...] because my hemoglobin is pretty low... So that makes the blood come back up... They told me it was for the baby's good..." (M012013)*

> *"My mom had me drink milk with panela (unrefined cane sugar), oats... with sesame seed for the anemia... lentils... have bell peppers with blackberries...liver, spleen. She told me all of that... beef lungs... and... to eat lots of liver... to make juice... but I never liked it... That helps to bring up the hemoglobin [...] It has a bad smell... but I drank it and my hemoglobin went up. I drink blackberry and agraz juice... boiled plantain that has lots of protein... with an egg.... I eat beans, lentils..."(M102013)*

Among the restricted foods are eggs, soft drinks, bananas and plantain. Warm drinks were unanimously reported as harmful. For the same reason, all elements, plants or activities that could bring "heat" to the mother's womb were rejected.

> *"You can't start drinking herbal teas, for example lemon balm or cinnamon... because that's like poison for the baby". (M102013)*

> *"I shouldn't drink hot things... I mean, having my belly, I don't like to drink them... But I do like to drink them when I'm not pregnant. While pregnant, no, nothing hot... I even cool down coffee with milk... No hot things because I can lose the baby". (M052013)*

The women showed greater adherence to the diet recommendations of health professionals that understood and respected their food habits, knowledge, and availability. Also, those foods considered necessary for the pregnant and postpartum women play a central role during the hospital stay, since family members tend to provide the women with food during their visits.

Interaction in the hospital setting

During the hospital stay, the family members are constantly present to advise the mothers on whether or not to consume

the food provided for them in the institution; they also bring them foods that they consider to be beneficial. They help them in activities like walking or bathing; they listen to the health professionals' instructions and then suggest which ones to follow; finally, they teach them how to take care of their children. The patients and family members generate solidarity networks in the hospital rooms, which are generally shared by three or more mothers, and they become emotional support for patients that are alone. The family members, therefore connect the domestic unit with the hospital and are mediators between the discourse of the professionals and the care practices of the mothers.

Discussion

The results presented above illustrate how the women's socioeconomic dynamics and the domestic care norms determine the characteristics of the pregnancy and postpartum, even in the hospital space. Some studies on maternity clinics in Latin America show that the social structures of class, gender, and race manifest themselves in the relationships between patients and health providers.[9,18] As observed in this study, when the patients occupy a marginalized social position, the knowledge of family members tends to be invalidated by the health providers,[8] who can be perceived as authority or aggressive figures.[19]

The analysis of maternal care in clinical spaces has focused mainly on the quality of the care that the patients receive from health professionals. Patient-centered care emphasizes humanistic principles, a bio-psycho-social perspective, and the rights of patients and their family groups to define their expectations of hospital care.[20,21] Studies of maternal care have also proposed care models centered on the patients[22] and the family,[23] with very positive results in the contraception and preconception,[24] prenatal care,[25] and birth[26,27] processes. While it has been argued that collaboration, respect, comprehensiveness, and consensus are fundamental characteristics of woman-centered and family-centered care models, our data points to two important absences. First, biomedical knowledge is understood as hegemonic, and family members are reduced to the role of accompaniment who are informed of decisions made about the patient's care. Second, they insist on the separation of the care dimensions.

This study evinced that care is a system of relations in which different knowledge circulates, wellness patters are reinterpreted and negotiated, and the behavior, expectations, and preferences of care are defined. Classic authors[28–30] describe three general spheres of care (domestic, institutional, and alternative), which could be observed in the women's narratives. Our data, however, demonstrates that the domestic unit, which includes networks of family members, friends, and neighbors, is the first and main care environment, which joins with the other spheres. Here is where decisions are made about when and whom to consult, whether to accept treatment, whether the treatment is effective, and when to change it or how to combine them. Care activities in this sphere include prevention, curing diseases, and dietary, hygienic, education, and recreational practices, among others. The narratives presented show the whole maternity care process is a domestic and feminine subject that is formed in constant interaction with different care agents.

Pregnancy, birth, and postpartum are determined by knowledge and representations surrounding the wellness and care of those who make up the social network closest to the women (family members, friends, neighbors). These notions are responsive to the discourse of the health professionals, but they do not take it as a single and absolute affirmation, rather as another element in a universe of care made up of multiple logics and legacies. On many occasions, the researchers observed how family members explained, reinterpreted, or contradicted the recommendations of the health professionals as soon as they had left the rooms. That is, the family members actively intervene in all of the spheres of care and are prime mediators between medical knowledge and the women's practices.

Conclusion

The analysis of the women's experiences permits the integration of economic, social, and cultural elements that determine maternal health, as well as the role of different care agents. Carefully observing and listening to these experiences made it possible to recognize that a focus on family-centered care does not only mean informing family members about the biomedical processes and including them in the bureaucratic logic of the visits but also recognizing their role as guides in the care process. To develop successful health education strategies, health professionals must accept that communication with pregnant women and their families is a negotiation of meanings related to wellness. An obstacle in this dialog is invalidating the knowledge of the pregnant women and their families, who perceive such an act to be an imposition against their knowledge and experiences that they have received from other generations and from their social networks. In the same way, recognizing the living conditions of these women and their families avoids reproducing in the hospital the situations of inequality that they live with outside of this space and helps to adapt the services to their needs.

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Conflicts of interest

The author Vanesa Giraldo-Gartner worked in the Specialized Medical Consulting Division of the Colombian Society of Anesthesiology and Resuscitation (S.C.A.R.E) during the development of the project.

REFERENCES

1. Vasco M. Estrategias de manejo mediante competencias no técnicas para la disminución de la morbimortalidad materna y perinatal. Rev Colomb Anestesiol. 2013;41:20–3.

2. Romero M, Ramos S, Ábalos E. Modelos de análisis de la morbi-mortalidad materna. Buenos Aires. Observatorio de Salud Sexual y Reproductiva, CEDES, CREP, IIE/ANM; 2010 Octubre. 8 p. Reporte No.: 3.
3. Pastor M, Herrera L, Vásquez I. Conocimientos y prácticas sobre autocuidado que influyen en la salud de la mujer, durante el embarazo y el puerperio. Rev Fac Cienc Méd. 2014;3:13–8.
4. Vásquez CL, Lozano MIP. Cuidados genéricos para restablecer el equilibrio durante el puerperio. Rev Cubana Enferm. 2011;27:88–97.
5. Montes Muñoz MJ. Cuerpos gestantes y orden social. Discursos y prácticas en el embarazo. Index de enfermería. 2008;17:25–9.
6. Sadler M. Así me nacieron a mi hija" Aportes antropológicos para el análisis de la atención biomédica del parto hospitalario [Tesis]. [Santiago de Chile] Universidad de Chile; 2003, p 175.
7. García-Jordá D, Díaz Bernal Z. Perspectiva antropológica y de género en el análisis de la atención al embarazo, parto y puerperio. Rev Cuba Salud Públ. 2010;36:330–6.
8. Dixon LZ. Obstetrics in a time of violence: Mexican midwives critique routine hospital practices. Med Anthropol Q. 2014;29:1–30.
9. Smith-Oka V. Bodies of risk: Constructing motherhood in a Mexican public hospital. Soc Sci Med. 2012;75:2275–82.
10. Beninguisse G, De Brouwere V. Tradition and modernity in Cameroon: the confrontation between social demand and biomedical logics of health services. Afr J Reprod Health. 2004;8:152–75.
11. Cartagena Cómo Vamos. Evaluación de Calidad de Vida 2014. Cartagena de Indias. Red de Ciudades Cómo Vamos. 2015 Septiembre 175 p. Reporte No.:10.
12. Rucks S. Bolívar y Cartagena frente a los Objetivos de Desarrollo del Milenio. Bogotá: Programa de las Naciones Unidas para el Desarrollo; 2012, p 146.
13. Vasilachis de Gialdino I. La investigación cualitativa. In: Vasilachis de Gialdino I, editor. Las estrategias de investigación cualitativa. Barcelona: Gedisa Editoral; 2006. p. 23–64.
14. Marshall C, Rossman G. Designing qualitative research. 3rd edición Thousand Oaks: SAGE; 1999. p. 344.
15. Agar M. An ethnography by any other name. Forum Qual Soc Res. 2006;7:36.
16. Sandoval CA. Investigación Cualitativa. Bogotá: Instituto Colombiano para el Fomento de la Educación Superior; 2002, p 313.
17. Giraldo V. De fríos y calores maternales: apuntes de un replanteamiento de la investigación. Red Posgrados CLACSO. 2012;20:14.
18. Smith-Oka V. Microaggressions and the reproduction of social inequalities in medical encounters in Mexico. Soc Sci Med. 2015;143:9–16.
19. Castro R. La vida en la adversidad: el significado de la salud y la reproducción en la pobreza. México DF: CRIM-UNAM; 2000. p. 541.
20. Frampton S, Guastello S, Brady C. Patient-centered Care Improvement Guide. Derby: Planetree Inc y Picker Institute; 2008. p. 247.
21. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. Soc Sci Med. 2000;51:1087–110.
22. Pope R, Graham L, Patel S. Woman-centred care. Int J Nurs Stud. 2001;38:227–38.
23. Zwelling E, Phillips CR. Family-centered maternity care in the new millennium: is it real or is it imagined? J Perinat Neonatal Nurs. 2001;15:1–12.
24. Dehlendorf C, Kimport K, Levy K, Steinauer J. A qualitative analysis of approaches to contraceptive counseling. Perspect Sex Reprod Health. 2014;46:233–40.
25. Farrell RM, Nutter B, Agatisa PK. Patient-centered prenatal counseling: aligning obstetric healthcare professionals with needs of pregnant women. Women Health. 2015;55:280–96.
26. Kaimal AJ, Kuppermann M. Decision making for primary Cesarean delivery: the role of patient and provider preferences. Semin Perinatol. 2012;36:384–9.
27. Ali M, Qazi MS, Seuc A. Seeking what matters: determinants of clients' satisfaction in obstetric care services in Pakistan. J Ayub Med Coll Abbottabad. 2014;26:481–7.
28. Kleinman A. Patients and healers in the context of culture. Berkeley: University of California Press; 1981. p. 427.
29. Zolla C, Carrillo A. Mujeres, saberes médicos e institucionalización. In: Figueroa J, editor. La condición de la mujer en el espacio de la salud. México, DF: El Colegio de México; 1998. p. 160–88.
30. Menéndez E. Intencionalidad, experiencia y función: la articulación de los saberes médicos. Rev Antropol Soc. 2005;14:33–69.