

## ORIGINAL ARTICLE

# RELATIONS ESTABLISHED BY WOMEN DURING PREGNANCY, DELIVERY AND POSTPARTUM WITH HEALTH PERSONNEL ACCORDING TO SOCIAL CLASS IN BOGOTÁ: QUALITATIVE STUDY

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## ABSTRACT

**Objective:** To understand the relationship established between women in a situation of pregnancy, childbirth and postpartum with the health services personnel according to social class in Bogotá (Colombia). **Materials and methods:** Qualitative study. Critical hermeneutical perspective and critical ethnography. Theoretical sampling. Analysis by triangulation in Atlas.ti. 9 women and 8 health professionals participated. 38 in-depth interviews were conducted for 13 months and 62 accompaniments to the maternal in the activities of prenatal control, vaccination, labor, postpartum consultation, follow-up exams, prophylactic pisco course, hospitalization and waiting room, both in public services as private. **Results:** There are inequalities according to social class in which the relationship between women and staff is configured in the following aspects: permeability to the needs of women, recognition of psychosocial aspects, having different points of view against a medical recommendation and right to complain or demand to improve. **Conclusions:** The situation described above intensifies gender issues in women with a less advantageous social class. It is necessary to develop interventions in educational and health institutions that consider aspects where human resources are sensitized on social issues related to the theoretical proposals of research and the democratization of medical information. It is unfair that the condition of social class and gender affects the quality of care and economically stratifies people's rights.

**Keywords:** Social Class; Interpersonal Relations; Pregnancy; Childbirth; Postpartum Period (source: MeSH NLM).

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## INTRODUCTION

There is evidence from all over the world demonstrating mistreatment of women during pregnancy, labor and postpartum (PLP) by healthcare personnel <sup>(1,2)</sup>. Even when public healthcare programs were introduced to implement respectful maternity care, the effects of these interventions were not satisfactory in all cases —physical abuse decreased, but other situations such as verbal abuse, neglect, and abandonment <sup>(1)</sup> did not.

The relationship between healthcare personnel and women during PLP is also a concern in Colombia, where investigations carried out revealed obstetric and gender violence <sup>(3-8)</sup>. Previous studies, which were carried out with women of different educational levels, failed to evidence the inequalities in relationships depending on social classes. This shows conceptual and methodological gaps in public healthcare research on this topic <sup>(9)</sup>, making it necessary

not only to deepen into the indicators of maternal morbidity and mortality, but also to the quality of health care.

This study is specifically based on theories proposed by Breilh and Menéndez<sup>(10-13)</sup>. On the one hand, Breilh's position is neo-Marxist, that is to say, social class is not a personal choice but determined by structural aspects. Thus, health inequalities reflect social inequalities. In this sense, social class is understood as a group of people who share common interests but have different levels of power, depending on their hierarchies in the work process, and this determines their ability to accumulate wealth<sup>(10,11)</sup>.

On the other hand, Menéndez focuses on critical medical anthropology, based not only on cultural differences (seen as a barrier between the biomedical system and the popular medical system), since it is also necessary to include aspects related to poverty and social inequalities<sup>(12,13)</sup>. The concept of a hegemonic medical model not only ideologically excludes the knowledge historically constructed by the subjects, but also ignores the poorest people and ethnic groups<sup>(12,13)</sup>.

On the basis of the above said, the objective of this study was to understand the relationship established between women during PLP with healthcare service depending on social class in the city of Bogota (Colombia).

## MATERIALS AND METHODS

Qualitative and flexible study<sup>(18,19)</sup> carried out with a theoretical and methodological approach, modified according to findings during the fieldwork. It was detailed in a methodological report<sup>(19)</sup> and reviewed by the research committee and external evaluators (reliability and auditability).

### Phases of the study and participants

The exploration began in May 2017, and the fieldwork began in November 2017 and ended in December 2018. This phase consisted on personal interviews as well as virtual communications through social networks, which created an environment of trust among the participants —the subjects could freely express their thoughts whenever they wanted. The analysis and writing of the information began during the fieldwork and ended in November 2019.

During this phase of the study, nine women from the city of Bogota, at least in the first trimester of pregnancy, and eight healthcare professionals whose sociodemographic characteristics are summarized in Tables 1 and 2. Women with mental illnesses or disabilities, minors and those who could change their residence did not participate. Women and healthcare personnel were contacted through social networks and the public sector prenatal monitoring service, three

## KEY MESSAGES

**Motivation for the study:** It is important to evidence the gaps in the literature, taking into account that women in pregnancy, labor and postpartum are frequently overlooked as subjects by health professionals.

**Main findings:** There are inequalities in the relationship that women establish with healthcare personnel according to social class.

**Implications:** Alternatives must be found in the care process that transcend the traditional biomedical model. Health policies require important transformations in the medical and health education system.

women refused to participate because they did not need the proposed support.

## Procedure

### *Epistemological perspective*

This perspective considered critical hermeneutics, i. e., elements from hermeneutics and elements from critical theory. Gadamer explains that the interpretation of hermeneutics is not “a reproduction of an original production” but a researcher-researched mediation, therefore it requires understanding, which is far from objectivity. Preconceptions are built by life experiences; this concept determines the way in which a subject can be interpreted<sup>(14)</sup>. Habermas combines interpretation and critical theory that requires objectivity to analyze the material conditions of the population. This author argues that preconceptions are not always legitimate, because traditions can be imposed, interpretation should serve to criticize ideology. Even if necessary, for understanding the subject's point of view, interpretation also reveals power relationships that allow developing emancipation<sup>(15)</sup>. The foregoing accounts for the complexity of epistemology —bricoleur researchers do not limit themselves to produce meanings of pure hermeneutics, since they can generate a resistance to the transformation of social conditions<sup>(16)</sup>.

### *Method*

Critical ethnography from Menendez's relational approach that links micro-social (relationship between subjects) and macro-social aspects (structural conditions)<sup>(13)</sup>, and Sheper-Hughes' position regarding the role of the researcher, who does not try to blend in with the population, but rather realizes that his

**Table 1.** Sociodemographic characteristics of pregnant women participating in the research. Bogota

Female participant	Healthcare system	Age (years)	Pregnancy weeks at the beginning of the study	Occupation	Education	Marital status	SES <sup>a</sup>	Source of income	Housing location	Healthcare services location
Gp	Prepaid	38	27	Entrepreneur, Private aesthetic medicine provider	Medical Professional (Postgraduate)	Married	5	Couple' work Properties	Usaquen	Usaquen
Ap	Complementary Plan C <sup>b</sup>	32	8	Housewife	Professional engineer	Married	3	Couple's work and properties <sup>c</sup>	Close to Suba	Chapinero
Lp	Complementary Plan S	34	32	Informal worker Researcher	Professional anthropologist (Postgraduate)	De facto marriage	3	Work (hers, couple's, father's)	Engativa	Chapinero, Usaquen
Kc	Contributory S	27	28	Salaried worker	Professional engineer	Married	3	Work (hers, couple's)	Kennedy	Kennedy, Teusaquillo
Ac	Contributory N	23	16	Salaried worker	Archive Management Technician	Married	2	Work (hers, couple's)	Bosa <sup>f</sup>	Bosa <sup>f</sup> , Chapinero Puente Aranda
Lc	Contributory C	18	20	Housewife	Bachelor	Single	2	Work (parents, siblings)	Bosa <sup>f</sup>	Kennedy Usaquén Puente Aranda
Ss	Subsidized ES <sup>d</sup>	19	25	Housewife	Seventh year of high school	De facto marriage	1	Work (couple's, mother-in-law)	Bolivar city <sup>f</sup>	Bolivar city <sup>f</sup> Tunjuelito <sup>f</sup>
Gs	Subsidized ES	36	20	Several informal jobs	Eighth year of high school	Single	1	Her work	Bosa <sup>f</sup>	Bosa <sup>f</sup>
Vs	Subsidized FF <sup>e</sup>	27	38	Informal worker	Bachelor	Single	1	Work (parents)	Bolivar city <sup>f</sup>	Bolivar city <sup>f</sup>

<sup>a</sup> Socioeconomic status. There are 6 status considered in Colombia, with 1 being the lowest and 6 the highest. This stratification is made according to the place of housing.

<sup>b</sup> Although two women have complementary plans, the companies that provide the healthcare services are different and therefore the clinics are different. This is also the case in the contributory and subsidized regime. Therefore, the first letter is placed to make visible the companies that are different. <sup>c</sup> Families that have the capacity to save and receive income from sources other than work (rentals, equipment rental). <sup>d</sup> Subsidized EPS. <sup>e</sup> Financial fund. <sup>f</sup> Vulnerable localities in the south of Bogotá with worse maternal and fetal health indicators, environmental contamination, deficit of public transport, insecurity, deficit of health services, prolonged transfers between home and health services, public health services involved in corruption.

or her presence in the community will transform his or her life and that of the subjects of study, for this reason, it questions in a respectful and critical manner, the health situations normalized by the population, which are aspects that contribute to oppression in the midst of poverty and inequality. However, this dialogue is bilateral, since it also allows the population to question it and things are learned from this as well <sup>(17)</sup>.

#### Quality criteria

Credibility and reliability were evaluated <sup>(13,18,19)</sup>, taking into account the participation of the main researcher who could change the subjects' behavior. During the fieldwork, situations affecting women's sexual and reproductive rights were revealed. In some cases, the participants normalized this situation and did not see the problem; in other cases, they sought help

from the researcher. The principal investigator provided documented information related to rights, helped to clarify medical terms, asked questions about their wishes and opportunities, and contacted support networks on sexual and reproductive healthcare and state institutions that monitor health care services. It all was done for women to have tools when making their own decisions so themselves, not the researcher, could be the transformers of the situations that occurred in the healthcare services, all of which is consistent with the epistemological paradigm chosen. The reference framework was built throughout the research process, which allowed, at the end of the research, the analysis of the results from different theoretical perspectives (credibility).

In the writing process, the discourses of the actors were differentiated from the analyses carried out by the research-

**Table 2.** Characteristics of healthcare personnel with experience in maternal care participating in the study, Bogota

Type	Workplace	Gender	Age (years)	Work experience in maternity (years)
Obstetrician, outpatient care, birth preparation	Prepaid	F	48	18
Breastfeeding consultant	Prepaid and contributive	F	41	21
Outpatient nurse	Prepaid and contributive	F	28	4
Doctor, delivery care, outpatient consultation	Contributive and subsidized	F	40	5
Outpatient obstetrician	Subsidized	M	54	25
Obstetrician, delivery care, outpatient consultation	Subsidized	F	32	8
Nurse, outpatient consultation, and pregnancy, delivery and postpartum preparation	Subsidized	F	46	15
Physiotherapist, delivery care, pregnancy, delivery and postpartum preparation	Contributive and prepaid	F	33	5

F: Female; M: Male

cher. The information recorded was made available to external evaluators who so they can verify the results found (reliability and auditability).

### Sampling

Theoretical sampling<sup>(19)</sup>, taking into account Breilh's concepts of social class<sup>(10,11)</sup> and the type of health affiliation in Colombia<sup>(20)</sup>. Three categories were differentiated according to the work situation related to social class<sup>(21)</sup>: subsidized regime (women with informal work, population without payment capacity), basic contributory regime (salaried women), and prepaid contributory regime or plans complementary (salaried women or businesswomen with the ability to pay for private services).

### Methodological strategies and techniques

Three to five in-depth interviews were conducted per woman during the PLP (with a live newborn) and information was collected at different points in the research process (credibility). Counting the healthcare personnel, there were a total of 38 interviews.

The interviews were carried out by the main researcher in an unstructured way with open questions<sup>(22)</sup>. A guide was used that included topics related to social class<sup>(9-11)</sup> and the meanings of the relationship of women with healthcare personnel<sup>(9,12)</sup>. The meetings were scheduled according to the availability of the participants in places chosen by them. The conversations were private and confidential: in social organizations, the home when the women were alone, and little frequented restaurants. The duration was one hour on average.

The main researcher carried out the participant observation<sup>(13,23)</sup> in the health services where the women attended (Table 1). 62 women were accompanied during pregnancy, labor and postpartum. The observations were recorded in a field diary. We sought not to block interaction with sub-

jects. The complete writing was done when not in the field. Accompaniment itineraries were constructed in an ethnographic manner, with descriptive and detailed information (credibility) that included: point of view of each woman (visibility of the PLP process in a historical and situated context), the position of other subjects different from the participants (credibility), the established dialogues and the reflexivity of the researcher. Statistical and epidemiological information was collected and it was used to build the context of the research, which helped to give meaning to the results. All of the above is available at Escuela de Graduados of Universidad CES in Medellin to inform of the transferability to other Latin American urban contexts with similar health systems.

### Qualitative analysis

Similar and different aspects among participants were identified in the accompaniment itineraries. This information was organized during the PLP, which allowed us to see recurrence of theoretical aspects over time by each woman<sup>(23)</sup>. The above was transcribed in an Excel file which was important to analyze the interviews, since there were aspects that seemed to be non-recurring, but when triangulated (credibility) with the accompaniment itineraries, they acquired theoretical importance.

The interviews were recorded by the main researcher and transcribed by two female transcribers from Universidad CES in Medellin. The transcriptions of the interviews and the accompaniment itinerary were given to the participants for feedback.

ATLAS.ti 7 was used for the analysis; a code was assigned to the paragraphs or phrases, which allowed classifying the information. We disaggregated data so we could link them again but in a different way, in the form of categories. This was done seeking to construct concepts related to the

theory (content analysis) and group data that have similar meanings, in order to construct concepts that give meaning to the results <sup>(24)</sup>. We could identify 179 codes derived from the data and organized them in 11 categories. Two categories are published in the results of this article. The coding process was carried out with the research group and a social worker.

The results were triangulated taking into account the methodological techniques (credibility) and the socialization process <sup>(18,19)</sup>. This was carried out with peer researchers from Universidad CES and experts in the field, outside the process, which allowed the inclusion of different and interdisciplinary perspectives (reliability, auditability). Likewise, the socialization was progressive with the participants to validate the information and propose strategies that emerge from themselves.

**Ethical aspects**

We obtained the approval of Universidad CES Ethics Committee (Act No. 99/2016) and the Secretary of Health of Bogota (Act No. N0041000/2017). According to the Colombian Code of Medical Ethics, the clinical decisions made by healthcare personnel were respected in the medical field, since the attention given by healthcare workers excluded the possible medical attention required from the principal investigator. In the informed consent, it was clarified who the researcher was and her interests as a woman, a physician and a mother.

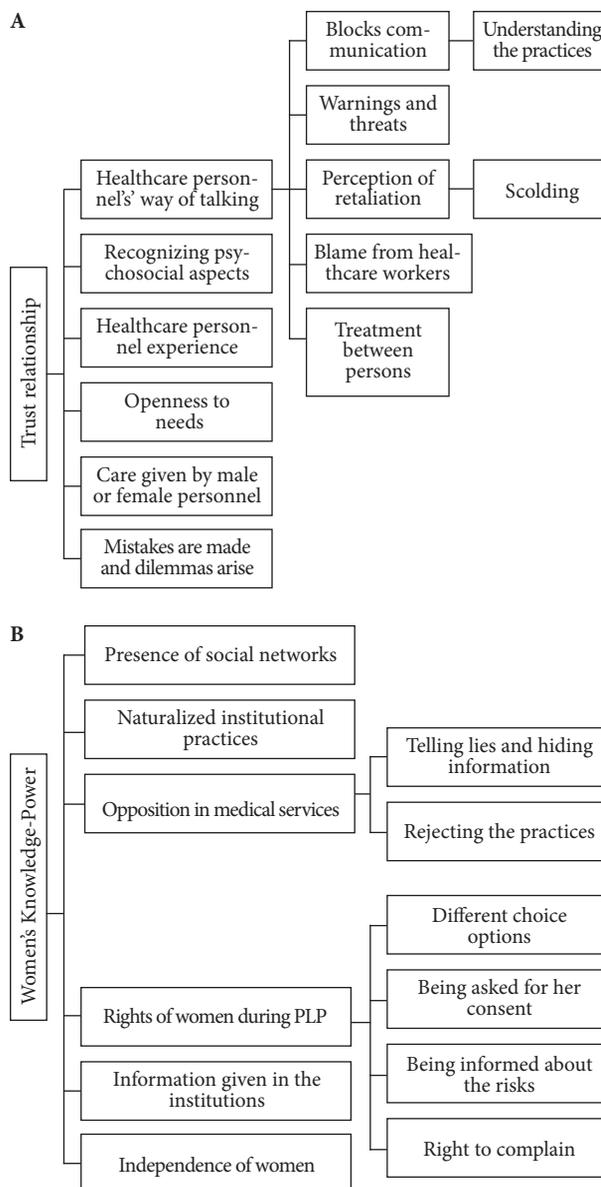
**RESULTS**

The following two categories were found (Figure 1).

**Trust relationship between staff and women (Figure 1A)**

Building links between healthcare personnel and women requires trust. This allows a therapeutic link to be established where women accept the recommendations of the staff and there is adherence to the initiatives of the health services. Confidence changes according to the aspects developed in Table 3.

The participant observation showed that several sexual and reproductive rights were violated in all the women participants, which implies that obstetric and gender violence affects different social classes. However, for women with a lower social class there are problems that are intensified to a greater extent. For example, the lack of openness to the needs of women and the lack of recognition of psychosocial aspects. In this regard, the healthcare personnel treated the participants as if they were ignorant and careless regar-



**Figure 1. A.** Trust relationship between healthcare personnel and women. **B.** Women's knowledge-power

PLP: pregnancy, labor and postpartum

ding their own PLP process. Women are scolded and judged when medical protocols are not followed. The social context is not taken into account since they are women who live in the most vulnerable localities of Bogota and with few social networks (Table 1A), which reduces the use of healthcare services. The pain in childbirth, breastfeeding, and medical procedures is naturalized by healthcare personnel and there are no alternatives to connect with women's feelings.

**Women's knowledge-power (Figure 1B)**

Women possess knowledge that they have built into their life stories, through the social networks that surround them

**Table 3.** Trust relationship category codes between healthcare personnel and women

Code	Conceptual definition	Textual quotations
Healthcare personnel's way of talking	It refers to the voice tone, the way things are said, the use of technical language, the absence of communication. The aspects that break the relationship of trust and block communication are: the guilt language, the warnings and the scolding as a punishment. The above issues were related to the perception of being treated badly, feeling bad at the hospital and not understanding nor accepting institutional practices.	<p>"The doctor said, 'Yes, it's more important to me as a scientist to check their heart is okay, but since it's so important for you to see their face,' and I was like, oh, how rude, I mean, it might be true, yes, but first, he doesn't have to rub in my face his scientific authority, and second, that's it, he could say, 'Look, this is okay,' you know, but do it in a way that's not so overbearing."</p> <p>- Specialized professional woman, informal work, complementary plan.</p>
Recognition of psychosocial aspects	Including the validation of emotions, understanding how women feel and who they are in the world they live. This aspect relates to the ability of the healthcare personnel to put themselves in the place of others.	<p>"We should be more unsettled about the emotionality of childbirth, but since we didn't see the chapter of the psychology of pregnancy and childbirth, we still have the dissociation from the academic root of only seeing the physical part. The treatment could be a little different, even if the health system hasn't changed."</p> <p>- Prepaid, subsidized obstetrician.</p>
Healthcare personnel experience	It is related to the expertise in a certain topic that gives women the security and trust in the care process.	<p>"I find the psychoprophylactic courses so boring... I find them boring because, for example, I know that the person who gives the psychoprophylactic course has never had a child... I know because she said so once. So I say that a person who has never had a child, who has never had that experience, who doesn't know what a contraction is... will say to you: 'You have to keep calm, you have to breathe and such' ... no, they have no idea!"</p> <p>- Professional woman, salaried, contributory regime.</p>
Openness to needs	It is the space that women have to participate in the care process, raising questions and concerns. It is the right to be heard without being scolded or judged.	<p>"There is not enough time for advice, to explain what option is better. When you arrive, they kind of listen, then prescribe something quickly and then finish the consultation, there is no, care. It is not the service that one would like to receive to clear all our doubts, but it feels so fast and often they don't even look at you, they just write on the computer and that's it."</p> <p>- Female graduate, informal work, subsidized regime</p>
Care given by male or female personnel	It refers to gender roles where the feminine is associated with empathy, permeability to women's needs and recognition of psychosocial aspects. The masculine role is the absence of all of the above. These roles can be assumed by both male and female healthcare workers.	<p>"They (female healthcare workers) supported me even more than my obstetrician. Once he arrived and only said I was not going to have a cesarean section, and that was it. But the others that were passing by, the (female) obstetricians on duty when my obstetrician was not there and they were checking me, they would tell me, you are doing well, don't worry. And I replied no, because my obstetrician told me such a thing. But they listened to me, at least they answered me. Instead my obstetrician came in the morning and came back after lunch and decided I was going to have surgery."</p> <p>- Professional woman, housewife, complementary plan.</p>
Healthcare mistakes and dilemmas	It is the users' perception regarding the errors that occur in healthcare and dilemmas that are visualized in the therapeutic approaches and decision making, as medicine is not an exact science.	<p>"I arrived with some contractions when I was 33 weeks and 5 days, it was so that the contractions should have stopped... But at that time, I ate a lot of potatoes and bananas, and I was very fat. I couldn't handle my weight, I think I gained about 20 kilos in that pregnancy, I didn't have a good diet, so I didn't have control. And when I arrived, it was easy for them to say that I was full-term, and they put me into labor."</p> <p>- Professional woman, salaried, contributory regime.</p>

and in health services. The way in which this knowledge is constructed determines the power and decisions they make in health institutions. The aspects related to this category are developed in Table 4.

Inequalities according to social class in the above aspects include having different points of view when faced with a medical recommendation and the right to complain or demand

for improvement. In these aspects, women with a lower social class are affected more. In this regard, the participant observation showed that the participants did not express their dissatisfaction with the care provided, nor did they structure formal complaints in the health services. When discussing this aspect with the women, they expressed fear of confrontation and their rights acquired a connotation in favor of public

**Table 4.** Women’s Knowledge-Power Category Codes

Code	Definition	Textual Quotes
Presence of social networks	It refers not only to the support women receive from their partner or family, but also from networks of women who help each other, healthcare personnel and healthcare workers (doulas and midwives) who weave alliances and empower women in health decision-making.	<p>“It’s outside the health system where you have to look for tools that let you empower yourself with what you’re feeling or what you know you can do. So, it’s by reading, by watching the news, by getting informed through the circle of women or people who surround that you who can tell if you that you can have a natural birth. This is contrary to medicine because medicine is like a practical thing to do: to schedule the agenda, the C-section, and suddenly decrease the risks.”</p> <p>- Professional woman, housewife, complementary plan.</p>
Naturalized institutional practices	These practices are built historically and normalized in the care process. They are not questioned either by healthcare personnel or by women and are exercised under power relationships where women lose autonomy in health decision-making.	<p>“I learned in the traditional clinic, but I have a willingness to go and train to do something new. What strikes me is that there is no willingness to go and learn new techniques in childbirth care and we are still anchored to what happened decades, maybe even 40 years ago, I don’t know how long. I am intrigued by why we don’t want to get out.”</p> <p>- Prepaid medical obstetrician</p>
Resistance in the health services	Women’s struggles for autonomy in health decision-making. For example, lying to staff, withholding information, and not accepting institutional practices in health head-on.	<p>“It really scares me, for example, I’m pregnant now and I’m still breastfeeding my 28-month-old son and I don’t want to tell anyone. I don’t want to tell the nurse because I’m scared, she’ll tell me something, and I’ll get more scared. So, I’m calm about what I’m doing, and I know that what I’m doing is not an excess, I know it’s controlled, yes. But if I go and tell someone then it’s going to cause a lot of things: I’m going to be scolded, I’m going to be told that it’s not right, they’ll tell me ‘you have to stop doing that’ and if I go with my husband then I’m going to have his pressure and that’s what I don’t like.”</p> <p>- Professional woman, housewife, complementary plan.</p>
Women’s rights during pregnancy, labor and postpartum	Rights that women know about, negotiate or demand in health services. For example, having different points of view in the face of a medical recommendation, the need to understand risks in order to internalize which ones to assume and which ones not to, and the need to understand informed consents and the birth plan. All of the above allow women to explicitly raise concerns and complain about the care.	<p>“The health teams tend to be what we could call ‘classists’; the patient who gets prepaid medicine, who is paying, who pays better rates or who is more annoying, is given better quality. Meanwhile, the patient of the contributory regime who attends a health institution, the care quality goes down. And for the patient of the subsidized regime who is attended and who is the one who pays the least or the one who can be the least annoying, in some cases can be given less time, less attention, less patience. And so that goes totally against the care we should have with our users, who should not have any difference in the assurance they receive and the care quality.”</p> <p>- Obstetrician on a subsidized basis.</p>
Information given in the institutions	Information given in health institutions that allows women to know their rights and improve the understanding of the Health and Disease Processes (HDP).	<p>“I went back to my gynecologist who doesn’t convince me and I’m looking for another one. I want to find a medical team that works under the principles of humanized birth, but let’s say that it has not been easy for me because the information offered by the complementary plan is very scarce, and I do not know who to ask within the medical institution.”</p> <p>- Specialized professional woman, informal work, complementary plan</p>
Women’s independence	Women’s gender and social class conditions that allow them to relate to health services and make decisions about the HDP.	<p>“I’m not as afraid as I was with my previous pregnancy, to feel pressured by my husband. First, because maybe the terror from the obstetrician was put into us both. So, obviously when you go with your husband, he’s also looking at you and telling you we have to do it because the life of our child is at risk. This time it’s just my body and I’m going to be a little bit safer and if I decide I’m not going to give in to the C-section, I’m not going to do it, and if I decide I’m going to change obstetricians as many times as I think it’s necessary, I’m going to do it.”</p> <p>- Professional woman, housewife, complementary plan.</p>

institutions. Similarly, there is a deficit of inputs and human talent in these services, reducing the alternatives for choosing personnel trained in humane practices.

## DISCUSSION

The findings showed changes in the doctor-patient relationship, taking into account that it is a social and intersubjective interac-

tion, and it results from its own socio-political context. There are structural factors that determine the functioning of health systems under the concept of supply and demand in the global market <sup>(25)</sup>. The doctor-patient relationship includes technological elements such as the use of the computer, which is relevant for the registration of data and acquires a value above the interaction of the subjects. Likewise, the relationship with the power of the administrative sector is visible, which diminishes the freedom of

the professional to respond to the market economy, subordinating the ethics of the healthcare personnel <sup>(25)</sup>. In this research, this problem is part of the structural barriers that institutions face in applying humanized practices in PLP.

In this context, the relationship between subjects is not important, but rather the results expected from the medical act. Technology is also transformed, since it is no longer an aid but is central to the structure of medicine. All of the above is more important than the patient, and medical work becomes dehumanized in a socio-political context that encourages this problem <sup>(25)</sup>. In this research, technology acquires a more important role than the signs and symptoms, and also than the accompaniment, when it comes to physiological and natural childbirth.

The patient-doctor relationship is eliminated by the institutional administrative agenda which is more important than the doctor-patient agenda. In this context, care is depersonalized, and meetings are automated. The doctor's agenda is structured on the basis of the spatial and temporal conditions of the medical practice. The space and time of this consultation is defined by the institution from an administrative framework that seeks to make medical management profitable. The doctor arrives in a space for which he prepares in his medical training and is forced to apply his biomedical knowledge in difficult conditions, since the time of consultation and the administrative activities that he has to carry out by institutional order eliminate the possibility of taking into account the socio-cultural aspects of the HDP <sup>(26)</sup>.

With regard to male and female identities, medicine has historically been masculinized. This is visualized in the discourse of the English medical society in the 17th century, where professionals are advised to avoid contact and intimacy with patients. In the 19th century, the concept of sympathy (understood as affinity between people who are attracted to each other) is identified in Victorian society as feminine and unscientific, as are doctor-patient relationships. In the United States, after graduating, some doctors integrated sympathy into their work, but others advocated more in favor of technology and separation from interpersonal relationships. These aspects have influenced the fact that in the 20th century, sympathy, defined as skills of an affective nature, has also lost its scientific value <sup>(27)</sup>.

Ignorance of the history of the medical profession allows this masculinization to persist today and the difficulties in integrating theoretical and practical knowledge are understandable <sup>(27)</sup>, which affects the healthcare for health service users, since they transit through health institutions where healthcare personnel work individually.

Violence against women in PLP has its origins in medical training, where there are hidden agendas that are learned

historically in academic settings. There is a disassociating habitus on the part of healthcare personnel who ignore the human character of women during labor, so it is possible that disrespectful behaviors are validated. The authoritarian habitus generates threats against women who do not follow medical orders, blaming them when they do not "collaborate" (call for the norm) in the delivery process and disqualifying the pain they feel. In the habitus in action, women are seen as inferior from the professional and gender point of view, which is relevant for the repressive rules that women accept in a subordinate way in a context where suffering is supposed to be deserved and the social reality of the population is ignored <sup>(28)</sup>.

Gender related issues are observed across social institutions <sup>(29)</sup> and health services are no exception <sup>(30)</sup>. In them, the related feminine and masculine roles are established, giving an account of the hierarchies developed at a social level <sup>(29,30)</sup>. Women's partners, present in the research, are excluded from the care process, assigning the reproductive role exclusively to women. However, men are included in the services when it is desired to impose certain institutional practices on women. Autonomy in decision-making about women's bodies is determined by the presence of the child, in which the state, health professionals and the father of the fetus play important roles.

Within the limitations, this research did not seek to generalize as population studies traditionally do, but rather to understand specific aspects of the problems raised in the research. A traditional ethnography was not carried out, where the researcher lives permanently in the field, but 13 months of observation were carried out, staying in the field at least three days a week. The participant observation was carried out only by the principal investigator, taking into account economic limitations. This researcher is not an anthropologist, but a doctor from Bogota, who is part of the context, and her vision could ignore other aspects that could be relevant in the analysis of the information. However, this public health research has been a collaborative work, where the support of social science researchers was relevant, who helped to build a comprehensive vision of the medical issues to be analyzed. It would have been possible for a greater number of people to participate, in search of the excessive amount of information in relation to social class, but given the established budget and schedule, more women could not be invited to participate.

In conclusion, it is necessary to develop interventions in educational and health institutions that take into account the theoretical and methodological proposals of this research

and the democratization of medical information. Health inequalities and inequities are preventable through public policies with a gender perspective that contribute to transforming both the health and educational systems in Colombia. It is necessary to study in depth the impact of the HDP on the quality of the care process and to identify the different masculinities that play important roles in women's relationships with healthcare personnel.

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