Understanding the meanings of motherhood: the case of a prenatal care program in a health center in Popayán, Colombia

La comprensión de los significados de la maternidad: el caso de un programa de cuidado prenatal en un centro de salud en Popayán, Colombia

Castro Franco, Bibiana Edivey[1]; Peñaranda Correa, Fernando[2]

[1]Psychologist. Specialist in Social Psychology applied to Organizational Effectiveness, Masters in Public Health. Professor, Universidad del Cauca, Colombia. bibianacastro01@hotmail.com

[2]Physician. PhD in Social Sciences, Childhood and Youth. Associate Professor, National Faculty of Public Health, Universidad de Antioquia, Colombia. fernandopenaranda@gmail.com

ABSTRACT The objective of this study is to understand the meanings of motherhood for different social actors (pregnant women and health personnel) within the prenatal care program of a health center in the city of Popayán, Colombia, a program developed as a strategy for the prevention and treatment of obstetric and perinatal complications. In order to uncover these meanings, a qualitative research study was carried out using interviews with social actors and observation of collective educational activities. Discrepancies were observed among social actors about the meanings of motherhood, owing to the influence of biomedical knowledge and the differences in power relations, as well as to particular cultural referents. The lack of recognition of these discrepancies affects the program's capacity to respond to the needs and socio-cultural characteristics of the pregnant women it serves.
KEY WORDS Public Health; Prenatal Care; Hospitals, Maternity; Qualitative Research; Colombia.

RESUMEN El objetivo de este estudio es comprender los significados que sobre la maternidad tienen los actores sociales (mujeres embarazadas y personal de salud) dentro del programa prenatal de un centro de salud en la ciudad de Popayán, Colombia, programa implementado como estrategia para prevenir y manejar en forma oportuna las complicaciones obstétricas y perinatales. Para ello, se realizó una investigación cualitativa basada en entrevistas y observación de las actividades educativas colectivas. Entre los hallazgos, se encontraron discrepancias entre los actores sociales respecto de los significados de la maternidad, debido al conocimiento biomédico y a las relaciones de poder, aunque también vinculadas a los referentes culturales particulares. Estas discrepancias no reconocidas afectan la pertinencia del programa para responder a las necesidades y características socioculturales de las mujeres embarazadas.
PALABRAS CLAVES Salud Pública; Atención Prenatal; Maternidades; Investigación Cualitativa; Colombia.

INTRODUCTION

Health care for pregnant women has been established as a public health priority by the World Health Organization (WHO) since its creation in 1948. The ratification of this priority at Alma Ata in 1978 led to the strengthening of prenatal care programs, within the so-called maternal and child health component (1 p.3-12), which in turn has led to policies, agreements and legislation both worldwide (2-10) and nationwide (11-12). Thus, maternal and child health has become a moral and political imperative for all nations (1).

However, as the WHO states in its *World Health Report 2005: Make every mother and child count!* (1), despite the abovementioned importance given to the subject, there are still certain serious problems in the health care provided to pregnant women and their families by the health sector, such as deficiencies in addressing the cultural characteristics and needs of women and their families (1).

An explanation of this situation may be found in medical anthropology. Martínez (13) suggests that the biomedical model has centered the understanding of life and disease in a biological perspective in which social and cultural dimensions are reduced to secondary causes or risk factors. It is therefore understandable that maternal and child health programs have failed to incorporate categories such as motherhood and parenting, as their understanding requires an ontological, cultural, social, and historical analysis (14).

Thus, from a critical and anthropological perspective, it is necessary to study health and disease by taking into account the individual's biography and his or her social relationships and cultural representations within a specific historical, economic and political context (13).

Therefore, it is necessary to expand the vision with which the actions of health systems are studied, in this case the prenatal program, which should be understood as a sociocultural reality. If culture is understood as a network of meanings in which people's behaviors become intelligible (15), understanding the meanings that motherhood has for the actors of the prenatal program is fundamental.

However, in order to analyze the meanings of motherhood in a biomedical setting, it is necessary to acknowledge that the prenatal program is a place where health care personnel and pregnant women position themselves differently and, sometimes, in conflict with one another, due to the power biomedical knowledge confers to personnel to define the meanings considered legitimate in that environment (16-21). It is also necessary to analyze the differences between these two groups regarding the meanings of motherhood as, according to Bourdieu and Passeron (20) and Bernstein (19), the educational biomedical discourse is recontextualized according to the cultural referent or cultural arbitration (20) of the institutional agent (21).

This article is the result of a research study entitled "Meanings of motherhood and pregnancy education for pregnant women and prenatal program personnel, at the South-West Health Care Center of the Social Welfare Enterprise of the State of Popayán, 2009." Due to the length of the final results of the study, the article will only include the findings referring to the meanings of motherhood for pregnant women and health care personnel.

METHOD

This was a qualitative research study with ethnographical influences, but it also utilized different techniques depending on the needs of the study, as suggested by Denzin and Lincoln for the *"bricoleur"* researcher (22). Thus, we have taken from ethnography the "in"-case study perspective which aims to understand the phenomenon in question (the meanings of motherhood) by taking into account both its interpretative and microscopic character (15). From this perspective, we do not attempt to generalize the findings to other human groups and situations, but rather our goal is to develop interpretations as theoretical constructs which may be useful in deepening our comprehension of the phenomenon (15).

We selected one of the prenatal care programs of the Social Welfare Enterprise of the State of Popayán (*Empresa Social del Estado de Popayán*) in Colombia, based on the following criteria: strength of the program (programmatic development, organization, logistics, professional background and experience of the health

care personnel) and members' willingness to participate in the research study.

The program has seven doctors, two head nurses and ten auxiliary nurses, who also participate in the other programs within the health center. The medical consultations offered to pregnant women last approximately 15 minutes. Doctors oversee those cases diagnosed as at-risk as part of their daily consultation routine, and uncomplicated cases are handled by the nurses.

The fieldwork was carried out between June and October 2009. During that time a total of 24 visits were made to the health center. Data collection was carried out through group and individual semi-structured interviews with pregnant women and health care personnel, and through observation of some of the program activities (such as HIV testing; this was the only group educational activity and the investigation was also aimed at understanding the educational process).

Interview guides were used that covered the following topics:

With pregnant women:

- meanings surrounding pregnancy, motherhood, the unborn child, and the woman's relationship to the unborn child;
- relationships with their partners and their extended family;
- meanings surrounding the prenatal program and its educational process;
- socioeconomic conditions of the woman and her family.

With health care personnel:

- meanings of pregnancy and motherhood in general;
- meanings which, in their opinion, the pregnant women who participate in the program attribute to their pregnancy and motherhood;
- meanings surrounding the prenatal program and its educational process.

The interview guides were gradually adjusted as a result of the findings and the process of analysis undertaken at the same time as the fieldwork.

At the conclusion of the educational activities related to HIV testing, the pregnant women were invited to participate in the research study. A total of six group interviews were carried out with those who agreed to participate. Groups varied in number, generally from six to eight participants. Some women who found the experience enriching participated more than once, because an environment of collective discussion and reflection was fostered that allowed women to share their needs, emotions, and anxieties in a supportive setting of understanding and respect. Three of the women who were interested in talking about their pregnancies and wanted to contribute to the research study were also interviewed twice individually. These interviews took place after the group meetings or at other times.

Two group interviews were carried out with the seven physicians and individual interviews were conducted with four of them. A group interview and an individual interview were carried out with the two head nurses. Finally, three group interviews were carried out with the auxiliary nurses (all attended the first interview, six attended the second, and four the third).

A total of 34 pregnant women aged 18 to 41 participated in the study, 18 of whom were multiparous and 16 of whom were primiparous, with gestations of between 10 and 30 weeks. They belonged to the socioeconomic strata 1 and 2 (the poorest population), corresponding to the population covered by the subsidized portion of the Health System. As regards their marital status, 18 were single mothers, 10 lived with their partners, and 6 were married. Regarding the level of formal education, 4 had attended primary school, 27 had some level of basic secondary education, and 3 had some level of technical or university education (not complete).

To keep a record of the information, field notes were taken and the interviews were recorded. Subsequently, the field notes were edited and the recorded material was transcribed. The analysis process was carried out at the same time as the data collection process, by coding and categorizing the data, based on a process of constant comparison (23,24). Categories were gradually constructed by taking into account both the findings and the central questions of the investigation. These categories orient the presentation

of the results in the article. It is important to note that the findings presented here include only the information gathered from the interviews.

The research project was approved by the Committee of Bioethics of the National Faculty of Public Health of the Universidad de Antioquia, as recorded in registry entry 034 dated June 17, 2009. The participants signed the informed consent once the purpose of the investigation had been explained to them and they agreed to participate voluntarily. They were explained that the information they provided would remain anonymous and that they were able to leave the study at any time.

RESULTS

We first present the meanings of motherhood for the pregnant women, related to the start of the pregnancy and its progress, the change in their identity and the role they assume as mothers, and the expectations they have regarding their child, parenting, and delivery. Then we present the meanings which, according to the health care personnel, motherhood holds for pregnant women.

For most of the women interviewed, pregnancy was initially perceived as a surprising and inopportune turn of events. Pregnancy signaled a novelty in their lives due to the physical, emotional and psychosocial changes it evoked. Differences were found in terms of the women's acceptance of their pregnancy and their role as mothers. Some of them felt their personal plans had been frustrated as they were forced to leave their places of residence, work, and study and, in general, abandon their life expectations.

> M9.–*I feel curious, afraid, happy, anxious. Curious when I think about the baby is developing inside, how it's forming; happy because it's my first pregnancy; anxious about the delivery.* (30 weeks pregnant)
> M1.– *I have dedicated myself to my children. I had my first child at the age of 14 and I was hoping that since they were growing older, I would get some rest, and be able to study and to work, but with the new baby, all my plans have been put on hold.* (10 weeks pregnant)

This unexpected situation – which for them meant not feeling ready – required of them time to adapt to their new condition, to imagine their unborn children and their role as mothers as well as to think about their futures and those of their children. The women did not envision dedicating themselves exclusively to their role as mothers and expressed that they were building an identity as mothers based on their own stories, needs and projects of a professional, occupational and sentimental nature. In this sense, they expressed their expectations of transcending that role, which they saw as only one of the many projects that they wished to develop, and thus they perceived some childrearing tasks as an obstacle to their personal interests.

> M16.–*It was a surprise, I considered abortion, but then I got used to the idea and I started to imagine the baby, I feel it moving when I talk to it.* (20 weeks pregnant).
> M10.–*I don't want to live like my mom, who loved us so much that she put her life on hold for us. I want to meet someone else, make a home with him and my son, go on studying and working at the same time. My mother fully devoted herself to us; she stopped living because of us. I say to her: "go out, get yourself some friends." I know she is happy but she's missing something.* (20 weeks pregnant)

They also spoke about the worries and concerns they had arising from the changes generated by their pregnancies: changes in their relationships with other people, especially family members, partners, friends and health care personnel. Furthermore, they expressed their concern and anxiety regarding their economic situation, in light of the demands that pregnancy and parenting imply. This situation made them feel vulnerable and in need of help. Some mothers expressed their need to make changes in their lifestyles during pregnancy, so that they could focus on their homes and reduce their circle of relationships. They also expressed changes in their emotional lives, such as an increase in anxiety and depression, which made their condition of insecurity and vulnerability even more complex. They therefore expressed the need to have their feelings and concerns be heard. They

expected to be considered individually regarding the distinctive features of their cases and their specific needs, and so demanded personalized and compassionate medical attention.

> M18.–*Here you get scolded: "such a little baby, such a careless mother." They scare me! They don't take into account all the effort it took me to even get them to see me.* (30 weeks pregnant)

The women who were abandoned by their partners appeared to be overwhelmed by their situation; both for them and for women who had partners, a partner was an essential source of sentimental, emotional, social and economic support. All the women interviewed also tended to feel, in that moment of their lives, the need for support from their mothers, whom they considered unconditional role models.

On the other hand, the women felt that the responsibilities of pregnancy and for the unborn child were mainly theirs, although they expected to receive support from other people and institutions in raising their child. Furthermore, they also felt they had an active role in building the relationship between the father and the child.

> M7.–*My friends tell me not to get so sad, because the baby senses it, my mood affects the baby. But it hurts me that the father doesn't acknowledge his paternity, that I got pregnant even though I was using birth control. The nurse asked me why I wasn't using birth control, but I was.* (10 weeks pregnant)

Expectations among the women varied greatly regarding the unborn child and their role in his or her upbringing. Some women expressed their fear of being totally absorbed by parenting, and so they hoped to foster the child's autonomy in order to avoid his or her excessive attachment as well as to share the child's upbringing with other family members and institutions. Thus, they considered it important to allow the social environment to influence the moral and cognitive development of their children. Along those lines, they did not feel inclined to prolonged and exclusive breastfeeding.

> M1.–*I'll get the baby used to the bottle, and if I have to go out, I'll leave it with someone, not always with me. With my first children, I only breastfed them, I didn't give them anything else. They grew dependent on me and I on them, and I could never go out.* (10 weeks pregnant)

Especially for those women who were pregnant for the first time, the raising of their children was an issue that generated anxiety and uncertainty, as they felt unprepared to enter motherhood. They were concerned about not responding adequately to the signals of the newborn child and about establishing a good primary bond between mother and child. In general, they were concerned and expectant regarding the education of their child and their role as teachers. They did not consider that these concerns about parenting had been addressed by the health care personnel in the program.

> M24.–*I have been thinking about how hard it must be to feed the baby. I wonder: what am I going to do when it cries? What will taking care of the baby be like? When should I change its diapers? In the first days, while I'm learning, I figure my mom and my sister will help me.* (24 weeks pregnant)
> M22.–[I wish] *they would teach me things about the baby, how to stimulate it, how to breathe during delivery, things you don't know. I've been reading about baby stimulation. Also, my family helps me with their experience, because at the health care center, doctors answer what you ask them and don't give you any additional information.* (30 weeks pregnant)

Initially, the unborn child was perceived as a stranger affecting the woman's routine and her projects; but as pregnancy evolved, this perception began to change as the child gradually became a being upon which the mothers projected their expectations and as the women developed images of their future that included the baby as an expected source of happiness.

This situation was also complemented by anxieties and fears about delivery, which became more evident as the due date approached. This

feeling was exacerbated by their concern about getting good quality care during the delivery, care they also hoped would be compassionate and respond to their particular needs and conditions.

The abovementioned statements of the mothers regarding how they experienced their pregnancies demonstrate ambivalent feelings such as frustration, fear, and anxiety intertwined with expressions of hope and positive expectations regarding the child. However, it is important to note that these women more readily expressed negative than positive feelings.

> M5.– *My friends say that the child limits [you] and that really worries me. I'd like to finish high school and go on to other things, but at the same time I'm afraid of doing things for myself and neglecting my child.* (20 weeks)

In the interviews conducted with health care personnel, we found them to have a general idea of how the women who attend the program experience their pregnancy. They also had their own perceptions and opinions regarding the type of feelings and views the pregnant mothers have about pregnancy and the unborn child. In some cases they considered the indifference and lack of motivation which they perceived in some of the women as an inadequate and harmful position for both the pregnant woman and their unborn child, a position that in their opinion required support and specialized treatment from other health care personnel.

> *You realize that by the third check-up the pregnant women seem happier, more willing; they are gradually coming to terms with their pregnancy, because in the first month they don't accept it, they're upset.* (Physician)
> *You could say that they are denaturalized mothers, that it's not in their blood to be mothers* [referring to the women who don't express positive feelings towards pregnancy]. (Auxiliary nurse)

Others expressed concern about the way women – especially teenagers – handle their pregnancy, considering them to be irresponsible or not committed to the health of their future child. In this sense, they perceived the dependence of these young women on their mothers as harmful.

In the opinions of the health care personnel we found a tendency, albeit with certain nuances, to understand motherhood from a perspective of exclusivity and unconditional devotion. We perceived in them a strong emphasis on the biological dimension of motherhood and pregnancy, as well as an ideal of motherhood as the foundation of a woman's personal fulfillment; for this reason, they consider that pregnancy must be assumed with commitment and taken as a priority.

> *When I see that the women are doubtful about their pregnancy I tell them: "motherhood is God's blessing, you have to trust Him." First I ask them whether they believe in God. It's that a woman doesn't know what it means to be a woman, or what happiness is, until she gives birth. I explain it like this so that they understand: "happiness for a woman is giving birth, having the baby and seeing that it's healthy."* (Nurse)

This priority was related to the function of reproduction and maternity at the service of the well-being and care of the physical and emotional health of the child. In this sense, there was a clear reference to women as having the ultimate responsibility for the health and well-being of the child. Thus, we found opinions regarding the women as those who have the final responsibility for prenatal care and, therefore, for the participation in the prenatal care program; or that the women's other projects and ideals must not compete with motherhood:

> *It makes me sad when an expecting mother doesn't show up, or when her priorities are out of place: even if she has many aspirations, the baby is the priority.* (Nurse)

An important tendency in the interviews held with health care personnel was the perception of the unborn child as vulnerable to the actions of the pregnant woman and to her social and economic conditions. In this sense, the child is considered a being in need of the protection and affection of the future mother and therefore a priority of the woman and a responsibility for the health care personnel.

Finally, we observed a tendency in the health care personnel to recognize their functions related to the biomedical aspect of prenatal care, but not to the emotional and socio-cultural aspects of pregnancy, motherhood and parenting; they expressed a lack of time for those issues, considered outside the area of their responsibility.

> *For lack of time, I don't give the women what they need. They need to talk about so many things. I see that they're anxious, worried, depressed, but I stop them [when they bring up certain things] or try to avoid subjects that might start them talking.* (Nurse)

DISCUSSION

In the following we present a proposal that aims to advance in the understanding of the findings of this research study. For this purpose, we will use theoretical contributions coming from social psychology, sociology and anthropology, which have been structured into three sections. In the first we analyze the meanings of motherhood for pregnant women, in the second the meanings of motherhood for health care personnel and in the third we will detail some of the meanings of childhood and motherhood which complement the analysis carried out in the first two sections.

The meanings of motherhood for pregnant women

Pregnancy in women, in particular if it is their first child, signals an important change which implies the construction of a new identity along with social and economic transformations (25,26). However, it also entails developing a representation of the future child and progressively building a bond with him or her (25,27).

According to Stern (25), the mother must achieve the "unique organization of mental life appropriate for and adapted to the reality of having an infant to care for" called "the motherhood constellation," as a response to internal and external (socio-economic and cultural) demands, especially the need to make the child grow and develop physically, the need to create a support system to strengthen her new role and the need to reorganize her identity.

Stern (25) also suggests that the child's birth alters the network of models the woman has regarding her partner, as father, lover, husband and man. Videla (28), on the other hand, highlights that pregnancy affects and is affected by the relationship of the mother with the extended family, due to the complicated network of feelings that are established within the heart of the family.

At the start of pregnancy, economic and social aspects and the woman's life projects are the highest priority in women, while the unborn child has a marginal existence. This is because these first aspects are evident in her life and arise from her own self-awareness (29), whereas the unborn child for most women is only confirmed by a laboratory test.

Stern (25) explains that awareness of the existence of the unborn child is strengthened starting in the fourth month of pregnancy, as the fetus is growing and developing inside the mother's womb. The same was observed in the pregnant women of this study; this was the period of gestation in which the interviewed women started to express their positive feelings about pregnancy more clearly.

The above can be explained by taking into account that around the twentieth week of gestation, women have had important opportunities to interact with the unborn child and consider it a part of them (25). The marginality with which the unborn child is perceived in the first weeks gradually gives way to a more ample and vivid representation of the child, which is also the product of the narcissistic expression of the future mothers regarding the fulfillment of some of their unsatisfied desires through their child (25,30). In this sense, they need to develop a positive identification with their child so that they can experience satisfaction regarding his or her existence – and that takes time.

In this sense, Bettelheim (31) explains the difficulties that human beings have regarding the acceptance of changes in their lives when they affect one's identity, and the natural resistance

they put up in the face of changes, as a narcissistic defense mechanism. In pregnancy, this situation is mediated by the relationships the woman establishes with the maternal figures of her support system (25), her relationship with the father of the child, and other determinants of her socioeconomic situation (28). This entire process occurs within the context of deep sociocultural transformations regarding the notions of family and the roles of women in society (32).

Thus, the women's initial reaction of rejection towards the pregnancy responds, precisely, to the abovementioned process of the reorganization of their identity, in which each woman comes into conflict with her priorities or finds herself in situations in which the pregnancy affects her socioeconomic and emotional situations, as well as her life projects or, simply, because motherhood was unexpected (28).

Additionally, the findings show that dependency on maternal figures, especially their mothers, is present in the women interviewed regardless of age. However, the dependency is more evident in adolescents, probably because they perceive themselves as more vulnerable and insecure about their new role. Some authors highlight the importance of the relationship model the woman has with her mother in the fantasies, hopes and fears of she builds around herself and her child (25,26).

From this perspective, we understand the ambivalent feelings expressed by the women regarding their pregnancy: interest and happiness at becoming mothers, but also frustration, sadness and uneasiness regarding the symptoms and limitations caused by pregnancy, and the demands in relation to parenting.

In this regard, Bettelheim (31) suggests the existence of contradictory feelings in parents regarding their children, as well as ups and downs in the relationship, described as part of the family dynamics, and which are finally balanced as the parents undergo processes of identification with their children.

Additionally, as was saw in this study, another important aspect is the woman's feeling of insecurity regarding the rearing, care and education of the child, when confronting her reality, knowledge and level of preparation in relation to her own expectations and those of society, in terms of the competencies demanded of her in her role as mother (25,26,28).

As a consequence of this identity-building process, in a context of emotional and socioeconomic vulnerability, the women yearn for and seek out the support of their families, their partners and the health care personnel in order to transition into motherhood. The mothers expect this support system to value, appreciate, instruct, and assist them in their parenting role (25,32).

The position taken by some of the interviewed women – referring to their intention of taking care of themselves, focusing on their homes and reducing their circle of social relations – may be understood as a retreat within themselves, as a way of strengthening themselves and coming to terms with the upcoming changes. Bettelheim (31) suggests that, in order to face the enormous changes a human being experiences throughout his or her life, he or she needs periods of tranquility and periods of activity in order to achieve a satisfactory development. This isolation – which could be externally mistaken for passivity – may come about when the processes occurring within the person are of such importance that the person is overwhelmed and is left with insufficient energy to perform actions directed outside of him or herself. Tranquility and activity are resources with which a person learns to understand and conquer both the internal and external world.

Thus the interviewed women expect to achieve a balance between their need to preserve their individuality and the demands that society places on them to properly fulfill their role as mothers (16,25,26,33). However, this balance is unstable because the conflicts they have to face change constantly, and in the search of that balance they will have to make concessions that will affect their identity restructuring process (34). The results of this balance will depend on their personal conditions, their support system and their sociocultural situation.

The meanings of motherhood for health care personnel

Health care personnel also have knowledge about these changes and the positions women take regarding their pregnancy and motherhood,

as well as the feelings, expectations and worries that they express. If these positions and feelings do not match with the health professionals' knowledge, conceptions and values, they start to question them, and they label them as unconscious problems which make it difficult for women to take on motherhood (28). In this sense, although health care personnel acknowledge the influence of the family support network (especially the partner and the mother) on the emotional state and the attitude of the pregnant woman, personnel mainly perceive the participation of family members in the program as way to homogenize the knowledge at the heart of the family, so that these family members do not interfere with the knowledge the health care personnel try to promote.

The attitude of censorship on the part of health care personnel responds to their difficulty in differentiating procreation as a biological fact from motherhood as a social and personal phenomenon affected by contextual factors (32,35). Thus, the health professional approaches his or her understanding of the situation of pregnant women from a biomedical perspective which tends to homogenize those experiences, given that the biomedical model is configured as a subuniverse of meanings (16) that greatly affect the professional's conceptions and actions and lend them a normalizing, interventionist, positivist (36,37,38) and medicalizing (37) orientation.

Furthermore, the cultural values of the health care personnel themselves are introduced as scientific parameters of evaluation, as the professional is unaware of the cultural influence contained in his or her educational discourse (19,20,35). What health care personnel value in pregnant women is their identity as mothers, and although health professionals can identify other roles and identities, they do not recognize these other aspects as legitimate. The traditional family models and maternal and paternal roles are therefore upheld, validated by disciplinary discourses (especially from psychology and sociology) as well as religious and political discourses which view women according to their function of childrearing and as the primary and most important provider of love and care for the child (35,39). These discourses are based on patriarchal principles and a biologicist perspective

which associates the ability to reproduce with motherhood (32,39). Thus, matters related to the emotional well-being of pregnant women and their socioeconomic conditions are overshadowed by the importance given to biomedical health care, but also because it is considered normal that women should sacrifice their well-being for the sake of their child (35).

Health care personnel, in their function as educators, affect the identity-building process in women without having a clear understanding of the phenomenon. In this sense, Todorov (40) suggests that it is dehumanizing to deny people the possibility to expand their identity, in such a way that their identity is restricted to a sole function.

On the other hand, the anxieties of pregnant women regarding their competence as mothers and in their parenting role, as well as regarding their primary relationship with their child, are not addressed by health care personnel, due to the fact that health professionals do not prioritize such aspects as part of their functions in the program. This situation is due to the fragmented perspective of the biomedical discourse, which avoids the sociocultural dimensions of health care (13) and makes it difficult for categories such as motherhood and parenting to be included in the structure of the educational activities of the program (41).

IDOLIZATION OF THE CHILD AND NEW MEANINGS OF MOTHERHOOD

The previous description requires a final analysis in relation to three sociocultural aspects which help us understand the situation analyzed in the two preceding sections: the idolization of the child, motherhood as a nonnatural dimension in women and new meanings of motherhood.

Idolization of the child in society locates the child as the center of the family; in this arrangement, women acquire recognition as the main provider of love, care and economic resources for the child. Thus, the main responsibility for the physical and emotional health of the child is deposited in the mother, as is the responsibility for early education, in the context of the overvaluation of childhood (25,35,39).

The ambivalent feelings in relation to motherhood found in this research study are important because they demonstrate that motherhood is not a part of women's nature and they show how difficult the situation is for some women to comes to terms with, given that pregnancy and motherhood are related to personal and sociocultural conditions (25,33,35,42-44).

The statements of some of the interviewed women regarding the critical view of the type of motherhood their mothers or they themselves modeled in the past, show a changing tendency regarding the meaning motherhood has today for women. Currently, women are attributing relevance to other aspects of their life and are not identifying themselves only in relation to their child; that is to say, they are building a meaning of motherhood which is not centered on the idea of sacrifice and unconditional devotion to the child, and they are trying to restore the idea that women are whole human beings. Thus, the possibilities for experiencing motherhood are not concentrated in one sole concept; on the contrary, what this research study shows is the plurality of meanings that motherhood has for women in the present day, meanings which are complex and paradoxical, and some of which may come into conflict with the meanings proposed by the biomedical discourse.

CONCLUSIONS

In this research study we found important differences between the meanings of motherhood for pregnant women and health care personnel, although we also recognized the heterogeneity existing within each group. This difference is ascribed fundamentally to biomedical knowledge, although particular cultural references also come into play. A better understanding of these aspects on the part of the health care systems and of health care personnel is therefore required in order to design and carry out more relevant and constructive policies, programs and interventions in relation to the needs and the sociocultural characteristics of pregnant women and their families. This implies creating environments and positions respectful of diversity in an increasingly plural world.

As evidenced in this research study, the health sector could better support pregnant women and their families by incorporating a broader, more transdisciplinary and more comprehensive perspective. It is also necessary to understand that the development of the child cannot occur at the woman's expense; indeed, the child's development is tied to the development of adults in parenting roles. Therefore, prenatal care programs should ask themselves how to achieve better quality pregnancy, delivery and puerperium care for women, not only from the point of view of biomedical indicators, but also in the sense of supporting in the best possible way the women's identity building process and their preparation for their role as parents, as per their request.

We consider it a priority to develop a comprehensive vision of motherhood in which the sociocultural factors are addressed, and in which motherhood is understood in relation to feelings and social meanings implied in the idea of being a mother. This notion recognizes motherhood as resulting from the selective and interpretative activity of people within a certain context, and not as inherent in women's nature (45).

Therefore, the process of transcending a homogenizing and normalizing vision will require alternative proposals which acknowledge the inclusion of the categories of motherhood and parenting as historical, ontological and sociocultural complexes and as central issues in the health care programs and actions directed toward pregnant women and their families.

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