interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Articles

Contemporary motherhoods: digital tribes and interactions with health institutions

Maternidades contemporáneas: tribus digitales e interacciones con las instituciones de salud (resumen: p. 17)

Maternidades contemporâneas: tribos digitais e interações com as instituições de saúde (resumo: p. 17)

Doris Elena Muñoz-Zapata[a]
<doris.munoz@upb.edu.co>

Beatriz Elena Marín-Ochoa[b]
<beatrize.marin@upb.edu.co>

Gladys Rocío Ariza-Sosa[c]
<gladys.ariza@udea.edu.co>

[a] Posgraduanda del Programa de Postgrado en Ciencias Sociales (doctorado), Escuela de Ciencias Sociales, Universidad Pontificia Bolivariana de Medellín (UPB). Circular 1 # 70- 01, bloque 7, Laureles. Medellín, Colombia.
[b] Facultad de Comunicación Social- Periodismo, Escuela de Ciencias Sociales, UPB. Medellín, Colombia.
[c] Departamento de Medicina Preventiva y Salud Pública, Facultad de Medicina, Universidad de Antioquia. Medellín, Colombia.

In contemporary times, mothers find in virtual social networks possibilities to contrast and question the institutionalized practices of health professionals. This study presents partial results on understanding the perceptions of Colombian mothers who participate in a digital network on motherhood, regarding their relationships with health programs focused on pregnancy, childbirth, motherhood, and parenting. Using a grounded theory method, one focus group and 17 interviews were conducted with women members of the group and health professionals. Mothers reported frustration perceptions in their relationships with the health professionals regarding inexistent support and insufficient knowledge before and after giving birth. As a conclusion, it is crucial that the programs may incorporate the needs for increased support over physical and mental health, as perceived by women.

Keywords: Motherhood. Pregnancy. Social networks. Health promotion and communication.

Muñoz-Zapata DE, Marín-Ochoa BE, Ariza-Sosa GR . Contemporary motherhoods: digital tribes and interactions with health institutions. Interface (Botucatu). 2021; 25: e200051
https://doi.org/10.1590/interface.200051

Introduction

In westernized societies, women going through the stages of gestation, birth, puerperium and the first years of life of their children, have permanent interactions with health professionals, in which they face the consequences of practices established in the lack of autonomy and the domination of the female body, typical of the patriarchal culture[1-4] and of the colonial epistemic project[5].

This is reinforced by the fact that women belong to less favored social classes[6], as well as by their ethnicity, marital status, and age, all of which are associated with a reproductive hierarchy[7]. In this way, social mandates and censorship are instituted referring to the ideal conditions for the exercise of motherhood.

The difficulties with respect to women's sexual and reproductive health reach extremes such as obstetric violence, a term that expresses a form of disciplinary power with actions that degrade and intimidate women in this area of their health[8]. Such actions are imposed in different countries of the world[9-12], in a more notorious way during the process of childbirth, by ignoring human rights related to health, maternity protection[7], sexuality and reproduction[5].

In the case of Colombia, the deep structural crisis[13] in the health sector, accelerated by Law 100 of 1993, intervened, a process that commoditized the provision of health services, distorting the guarantee of the rights to health, by privileging the economic profits of companies in this sector, to the detriment of quality. This health model also limited the autonomy of professionals and users in decision-making by introducing greater controls for authorizations in the care of individuals and restricting access to procedures.

In spite of the fact that women come to health programs in search of the social support[14] needed to face the challenges inherent to their motherhood[15], they mostly find institutionalized practices[16] that do not acknowledge their needs and life contexts[3], leaving them lacking the support required in these stages of their motherhood[7].

Consequently, many mothers aim to make up for these shortcomings in information and social support[17] through virtual social networks, in which they also find affective tribes[18] through elective sociability with like-minded people. These become a support for their motherhoods, besides allowing them to confront medical practices and indications, as well as support in the face of counterhegemonic choices regarding upbringing[19].

In this context, this research investigated the perceptions of Colombian mothers, members of virtual social networks about motherhoods, with respect to their interactions with health professionals regarding pregnancy, childbirth and the first years of life of their children.

The purpose of this work was to contribute to the problematization of the health needs of mothers and their families, in order to strengthen existing programs and emerging public policies in the country, such as the Routes of Integrated Perinatal Maternal Health Care[20].

The research was based on the understanding of motherhood as a social and historical construction[21,22], which is needed to question excessive medicalization and gender relations in health settings[2], as well as readings focused on the experiences of mothers, in accordance with matricentric feminism[23].

Methods

This article describes the partial results of a doctoral thesis, which was based on the Grounded Theory[24], from which open, axial and selective coding was used for data analysis and category generation. The analytical process was aided by the NVIVO version 12 program.

The population of the study encompassed members of a Facebook group created in 2014, with 6,228 followers, located mainly in the department of Antioquia (Colombia), as well as other cities in the country and even other Latin American countries.

This group focuses on issues of pregnancy, childbirth, motherhood and parenting. It is also characterized by its independence from institutions and brands, as it has no sponsorship. Among its principles, it declares itself as a promoter of breastfeeding and prohibits the recommendation of medicines.

An intentional sampling was made. Among the criteria for inclusion there were considered: women mothers, legal age, members of the group and that from this participation they have generated face-to-face relationships with other members. Professionals chosen to participate are part of the group by supporting the mothers in mental health issues, parenting, breastfeeding counseling and doulas[(d)]. The saturation of categories was the criterion for the analysis of the information and to determine the number of interviews. In total, 17 interviews were conducted, 15 of them with women (mothers and health professionals).

To carry out the semi-structured interviews, a guide was prepared with questions in which the following analytical axes were explored: virtual social networks on motherhood, interactions with health professionals during pregnancy, childbirth, puerperium and the first years of life of the children. The invitees were contacted by digital media (Facebook and Whatsapp) and invited to participate in face-to-face interviews.

The focus group was conducted with five mothers belonging to a tribe[(e)] created from the group. Motivational questions were used with them to hold an open conversation about the issues and to seek closeness to the type of interactions they have in their daily relationships[25]. The fieldwork happened between September and November 2019.

[(d)] Doulas are persons trained to accompany women and their families in the processes of: preparation for birth, labor (in which they accompany the mother if the clinic allows it) and postpartum. They also support the families' doubts and difficulties in adapting to the arrival of the new baby.

[(e)] This is how the mothers of the Facebook group call the groups that have been generated from interactions on Facebook with those they share in everyday life through other WhatsApp groups created by them, as well as in face-to-face meetings.

Table 1. Interview participants

Participant (Fictitious name)	Age (years)	Schooling	Number of children and ages	Occupation	Condition
Angela	37	Post graduate	2 children 3 years and 11 months	Lessons 2 hours a week	Group member
Cristina	30	Engineering, graduate course	2 children 4 years and 5 months	Sales entrepreneur	Group member
Daniela	32	Engineering, graduate course	2 children 2 years and 2 months	Housewife	Group member
Lina	28	Technical studies	2 children 9 years and 4 months	Part-time employee	Group member
Mónica	36	Health profession graduate course	1 child. 3 years	Health sector employee	Group member
Facebook Group creator	31	Gastronomy studies	2 children 5 and 3 years	Family counseling	Moderator
Antonia	26	Technical studies	1 child 2 year	Doula	Moderator
Social Worker	51	Graduate studies	Two daughters >20 years	Volunteer	Moderator
Lisa	38	Engineering, graduate course	2 children 7 and 4 years	Civil Service employee	Moderator
Psychologist, gender approach	32	Graduate studies	2 children 6 and 3 years	Psychology care	Professional member
Psychologist, expert en respectful rearing	37	Post graduate	1 child 2 years	Workshops with families	Professional member
Ob-Gyn	55	Post graduate	Two daughters 20 years+	University faculty and clinician	Support professional
Specialist physician 1	50	Health PhD	1 child >20 years	Advisor in projects and university faculty	Support professional
Nursing specialist 1	30	Masters' degree in Education	0	Head of the educational program for mothers	Support professional
Nursing specialist 2	40	Graduate studies	1 child 3 years	Head of the program for baby care	Support professional
Professional, Milk League, Antioquia	40	Graduate studies Social Sciences	1 child 18 years	Education sector employee Volunteer	Support professional
Specialist physician 2	60	Graduate studies Health	Two children > 20 years	Head of the program for infant care	Support professional

Table 2. Focus group participants

Participant (Fictitious name)	Age (years)	Schooling	Number of children and ages	Occupation	Condition
Lucia	40	Engineering, graduate course	1 child 3 years	Employee	Group member
Marcela	34	Trading, graduate course	1 child 3 years	Employee	Group member
Liliana	39	Education, graduate course	1 child 4 years	Housewife	Group member
Bibiana	26	Engineering, graduate course	1 child 2 years	Part-time cosmetology	Group member
Mari	28	Engineering, graduate course	1 child 3 years	Employee	Group member

The categories resulting from the research analysis were: expectations regarding the health sector, difficulties with health interactions, and the delivery as a milestone in interactions.

The project was cleared by the Health Research Ethics Committee of the Universidad Pontificia Bolivariana of Medellin (Colombia) and recorded in the minutes of August 16, 2019. An informed consent form was filled out with all the participants of the research, certifying that they knew the details of the research, as well as the voluntary nature of their collaborations.

To guarantee confidentiality to the research participants, the real names were changed to fictitious ones, as well as the names of the clinics and health institutions mentioned in the interviews and the focus group.

Results

The participants' theory about their interactions with healthcare professionals in their maternity and childcare settings is described below.

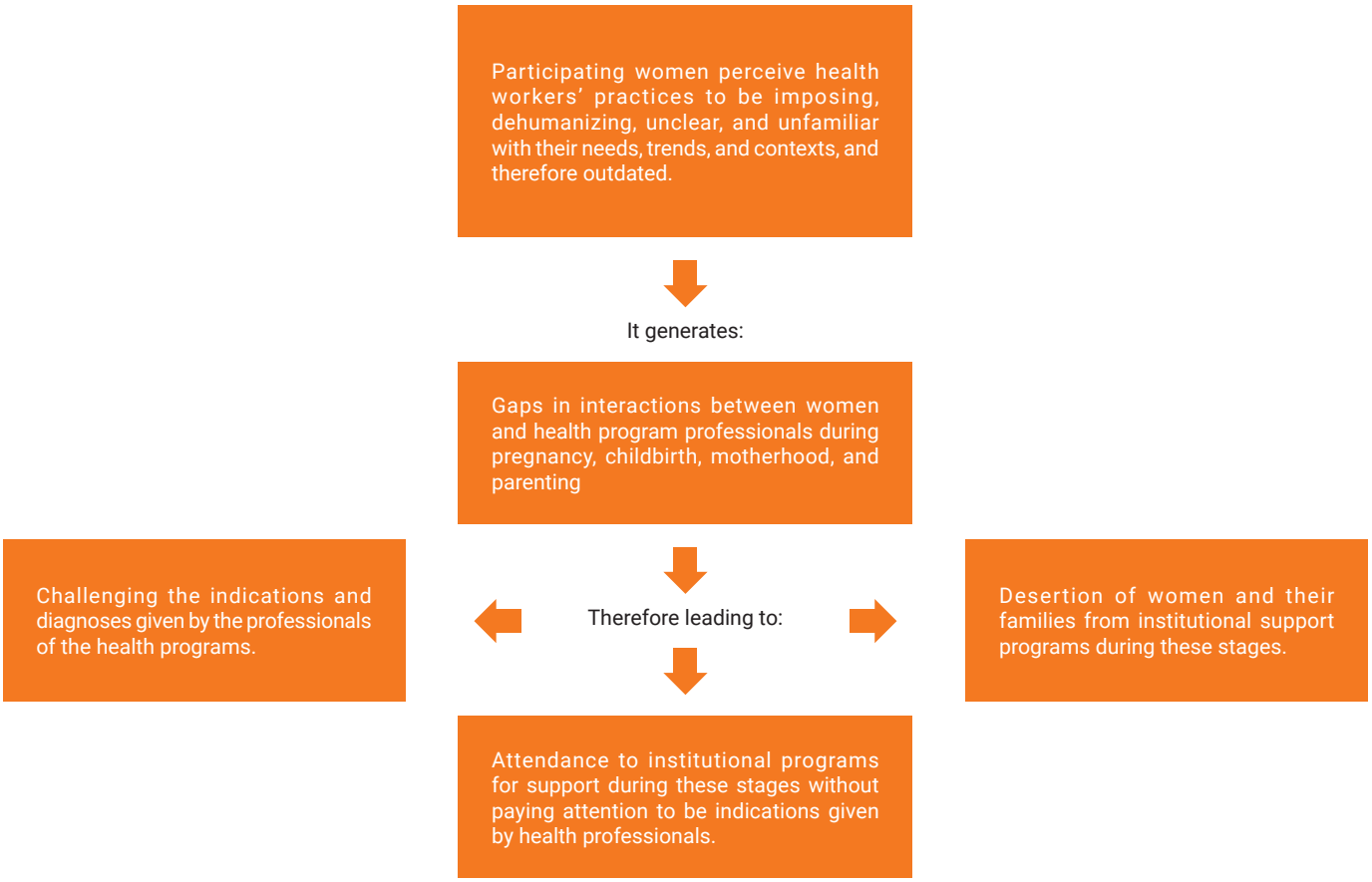

Figure 1. Theory regarding interactions with health Institutions during pregnancy, delivery and motherhoods
Source: Created by the authors, from the results of the research

The women began to perceive difficulties in communicating with the professionals who cared for them since the prenatal checkups, as they did not feel listened to, nor understood in their physical and mental needs. They felt disinterest and even contempt for their own knowledge, such as that related to the search for a respected labor, so they chose to hide these concerns in subsequent medical consultations.

Participants reported dissatisfaction in their interactions with health professionals, due to their impositions on various health and parenting aspects, as standardized attitudes, unaware of their contexts and life expectations. This feeling was more noticeable in relation to the programs addressing growth and development, created in Colombia to follow-up the first ten years of life in terms of health.

With respect to programs to prepare women for childbirth and motherhood, women perceived that they were not provided with the necessary preparation to assume childbirth, and even less so for what they would have to face after the birth of their children, with the changes in personal and family terms:

> With respect to the medical system, I focus a little more on pregnancy and childbirth. I think it's extremely important because, in other words, you enter the world of motherhood and you fall like a balloon, in other words, you don't know anything. (Liliana)

The mothers emphasized the exclusion of mental health in the programs of prenatal control, in spite of the priority of this aspect due to the hormonal changes and of life in general, that live from the pregnancy and continue during the first years of life of their children:

> When you go to the pregnancy checkups they do not ask how you have felt, how you are, emotionally what you have felt these days. (Marcela)

Delivery as a milestone in interactions

For mothers, the delivery was a milestone in their interactions with health professionals in their care practices, as it became an unforgettable moment. They remember in detail the positive and negative aspects of the different actors who participated in the birth of their children, such as medical and nursing staff and even stretcher-carriers, doormen and administrative staff of the health institution.

Most of the participants perceived dehumanization in the professional treatment provided during the delivery. Also, communication problems related to the aggressive tone towards them, as well as the lack of listening to the needs felt in that process. In this regard, the mothers also did not receive satisfactory information or explanations about the decisions made by the health personnel.

This had an impact on the definition of obstetric violence referred by the mothers in front of their deliveries, which also linked the absence of their consent to the actions of health personnel, as well as the lack of empathy and the abuse they received. The women even described sarcastic words such as the following:

> And she kept telling me that as if I had done it, that I was so young, that as if I had thought about it and as if I had done it, I also had to put up with it to have it. (Lina)

The lack of company by a loved one or a close friend during childbirth is also one of the aspects that remain as a mark. On the other hand, they remembered the chill experienced in the operating room or in the delivery room, which made the process even more difficult.

The women's experiences during their childbirth processes were crucial, because they left traces that took time to heal and even consider that negative experience as a trigger for postpartum depression.

Women consider the postpartum stage and the transition to motherhood as a period without sufficient accompaniment by the institutions with respect to their own health and accommodation to the new life, since the existing programs only focus on the care of their babies:

> During the whole gestation you have controls with the obstetrician, with the nutritionist, with the doctor of I don't know what, and then one has the baby and they already forget about one... and now OK, it's only the baby. (Lina)

Difficulties with health interactions

The participants experienced frustrations as a result of interactions with the health professionals who attend the programs and consultations during the first years of life, in factors such as: the contradictions they perceive between the different professionals who care for them, judgments about the decisions they make regarding parenting, devaluation of their knowledge, in addition to criticism regarding issues of couple intimacy such as sleeping with their children in the same room.

> But the biggest difficulty for me was always growth and development. Terrible, terrible. Once I was called to scold me because supposedly I had not taken it, they said: The child has his right! And so those group growths and developments are the worst things in life. As a health professional, I go there and I am destroyed by what I hear there. (Monica)

The women explain their differences with the practices of the health personnel, from structural aspects such as the incidence of social class aspects in the type of attention they receive, the lack of autonomy they have to make decisions regarding their bodies and their children's health. In addition, they are afraid to express their discontent for fear of the subsequent consequences on the provision of the services they receive and, above all, on that of their children.

Difficulties with health professionals are also based on aspects such as authoritarian language that exalt their power over the women they serve. They perceive a great ego on the part of the professionals, making communication difficult from the beginning.

Women place part of their frustrations in the so-called lack of updates from the health personnel, which refers mainly to critical comments regarding prolonged breastfeeding (after the first year of life of their children and even in some cases, after the first six months), while other institutional actors, of great relevance to them such as the Milk League[f], indicate that this is a personal decision.

This lack of updating also includes the lack of knowledge of professionals about contemporary trends in child rearing and care, such as: bedding, carrying[g], complementary feeding directed by the baby after six months of age (Baby Led Weaning), and free movement, which consists of respecting the rhythms of development in the face of the handling of the body and experimentation with the possibilities of movement without constrains, from the first months of life[26,27].

The conviction that the professionals are out of date in various child health issues makes mothers assume a defensive and confrontational attitude, in the face of the indications received in the medical consultations and in the growth and development checkups:

> These are fights that we fight with, I have had friends who take printed documents from the WHO for those outdated people, to read. (Psychologist)

These difficulties even lead to the desertion of mothers and their families from health programs:

[f] International non-governmental organization that works for breastfeeding in several countries around the world and conducts support groups with mothers and their families to maintain breastfeeding. It is a comprehensive source of information for this population through the website: e-Lactancia.org

[g] Carrying is a practice that consists of carrying babies attached to their caregivers' bodies through sling or ergonomic carriers, in line with a form of parenting that seeks attachment from birth. This trend is an adaptation of thousand-year-old practices carried out by indigenous communities

> For me, the growth and development program is not liked, it seems to me that it is the most invasive, the most disrespectful thing that can exist, at least the two times that I went and I had to go almost as an obligation because the kindergarten asked me to bring the growth and development card. (Marcela)

The mistrust generated by the perception of outdated information and the contradictions of health professionals, make women seek alternative spaces to contrast and even question this information and make their own decisions about it:

> The first information I get, for example with the topic of breastfeeding is: that I have to give 20 minutes of one breast, 20 minutes of the other breast, every three hours, and what I find the Facebook group: free breastfeeding, every time he/she asks, for as long as asked, everything that is asked. Then of course, as I had already made the decision of respectful parenting and I already had, like another support for that decision, I left because of what I found in the group. (Angela)

Another element that makes the mothers uneasy is the following:

> My baby has been seen by three pediatricians in four months and one tells me one thing, the other one tells me another and the other one tells me another, then I go home, sit down, analyze and pick the best I can. (Lina)

In this sense, women even refer to diagnoses that when they look back, they consider it to be wrong:

> When my son newborn got sick, my son was in the ICU one afternoon and I was crying like a Magdalena, I would go out and come back. But I forgot all about speech therapy, I was just a mom. I went through the most difficult things, they told me that it was my fault that my son was sick, because I was in exclusive breastfeeding: how would you dare? Exclusive breastfeeding this child? (Monica)

Regarding the care received, women perceive that social class plays an important role, tangible through the type of social security affiliation (public or private, with or without complementary services such as insurance and prepaid medicine):

> Sadly, but that varies a lot depending on whether you have EPS, prepaid medicine or are under a subsidized regime; it varies a lot, both the care and information you are given, which should not be so, because in one way or another we are talking about health, we are talking about human beings, and we all deserve the same treatment, but it changes a lot. (Lina)

The access care close to the requirements they perceive as necessary, needs additional payments in the health regime. They also look for particular pediatricians and gynecologists, recommended among themselves, judged to be respectful of women and their upbringing styles.

However, some women who have these private health services complained about the attention they received:

> As I have prepaid, but it's like a recipe, what Marcela said about Growth and Development is like a recipe: you are in the eighth month, you must be doing this, maybe it's the same as for childbirth, you are in the sixth, so you have to do this, I don't know how to do things like this, and the prepaid plan because I was not buying the story of humanized childbirth. (Lucia)

Expectations of the health sector

Despite the difficulties exposed above, mothers expect support from professionals that work in health programs during these processes of their lives, in scenarios of understanding and good treatment. These expectations also refer to the inclusion of psychological aspects for the accompaniment during these stages, and the valuation of other knowledge such as that of the doulas at the time of delivery.

The women considered that the health stakeholders could contribute a lot to the difficulties they live in their motherhoods. This requires, in the first place, information and knowledge, but more in line and respectful of their needs and life contexts.

They demand a closer and more humane treatment, acknowledging what they know about themselves and even the so-called instinct in front of their children, referring to the knowledge they have of them. Their greatest expectation in this sense is to empower themselves and make their own decisions based on the information and knowledge they have acquired.

Participants from the health sector mentioned the humanization of childbirth in Colombia as a pending challenge, which they face in their individual practices and in the training of medical students since 2014.

Discussion

Contemporary women interviewed have conducted searches take motherhood autonomously, which supports their information requirements about this topic in the Internet and the social networks. Also, in the gaps that they perceive regarding care of institutional health programs, which concentrate on the lack of orientation facing the aspects that they felt relevant regarding their own care, and the implications that the new motherhood generates in their lives and their mental health.

For some participating women, digital social networks even become the only opportunity to access the information and support they need for the stages of pregnancy, childbirth, puerperium, motherhood and parenting.

The participants challenge the communication with health professionals, coherent with the framework in which doctor-patient relationships should be considered in the contemporary world. According to Petracci[28] these relations should be based on the right to communication, the gender perspective and the autonomy of the women in their role as patients, to the extent that they need to be active in making decisions in front of their bodies and to be heard in their contexts and needs. The right to communication requires a more horizontal, more symmetrical doctor-patient relationship, i.e., one in which there is a balance of power in benefit of the well-being and satisfaction of both parts, as well as the quality of care.

The difficulties in the relationship between the participating mothers and the health personnel also stem from the lack of understanding of the language used by the professionals, something relevant considering that the women who participated as mothers mostly have high educational levels (undergraduate studies) and leave the questioning to what those women without higher education understand.

This is consistent with the criticism of health personnel and institutions as disciplinary control devices that reinforce the subordinate place of women in the patriarchal society[29].

The perception that programs to prepare for childbirth and motherhood are limited to biomedical aspects and ignore the identity component that resulted to be fundamental to prepare for parenting, coincides with other studies[30], which have shown the lack of knowledge in Colombia by this type of educational programs[31] regarding the complexity that mothers face in parenting.

This connects to the relationship between social class[6] and health care, which in the case of the participants, differed mainly in that those, who did not have private health coverage at the time of delivery, considered their care inadequate, but assumed that they would have had the advantage of having a complementary health plan, thus enjoying higher quality care and make decisions.

However, those women who had private health coverage reported that they could not really decide what they wanted, despite choices such as the clinic where they would have their children, support professionals, and the company of their partners during birth.

So, beyond the problems associated with the relationship between social class and health care, the difficulties and frustrations that women experience in their interactions with health professionals' practices during these stages is originated in the biomedical model, its patriarchal[2] and epistemic colonial[5] characteristics.

The devaluation of the knowledge of the women participants transcends those related to their own bodies, in coincidence with the basis on which medicine is implemented in the Western world[2]. This shows that in this population the awareness emerges in the face of the asymmetry in relationships and the control imposed on them and their bodies in the context of institutionalized practices.

The fear of punishment for demanding what is considered a right in the hospital context regarding care in the processes of pregnancy and childbirth coincides with the comparative analysis of Foucault's concept of prison[32]. In this regard, Arguedas[8] compares the exemplary punishment of prison to the treatment received by women

who complain or protest, so that others should consider the consequences of doing something similar.

The feminist perspective[22], which is linked to the difficulties described by women in their interactions with health practices, denotes aspects related to the domination of the female body which, according to Bourdieu[1], are instituted within the patriarchy and, and in turn, are responsible for keeping it in place.

In this sense, a counter-hegemonic vision begins to emerge on the part of some women who participate in the group under study, with respect to the domination imposed on their bodies in pregnancy and childbirth. This vision is in line with discussions undergoing in other countries of the continent[33-35].

This questioning leads to a demand for autonomy[36] in relation to their bodies and their relationship with their children, which also considers a health ethic[3] and a feminist bioethics that promotes respect for the vulnerability of these vital processes, from a critical decolonial perspective that revalues the subaltern knowledge of women[5].

Finally, it is pressing to denaturalize the discourses and practices that legitimize obstetric violence in Colombia[37,38], in order to advance in the humanization of care during pregnancy, childbirth and postpartum, as an accessible right for all women, in convergence with emerging mobilizations in other Latin American countries, such as Costa Rica[39], Argentina[40] and Brazil[35], in which ownership of public policies in this regard has begun.

Conclusions

The Colombian mothers interviewed are building new ways to assume their motherhoods, as well as pregnancy, childbirth and parenting. They are resignifying their motherhoods to make them counter-hegemonic, that is, more aware, critical, and less subjected to the predominant health and social norms. For this purposes, they find a very valuable support in the virtual social networks.

This study finds that, in the case of the participating women, the disagreements with the professionals in the institutionalized health practices constitute a cause to assign a great value to the digital network in front of the topics related to pregnancy, childbirth, maternities and upbringing.

Despite the existing tensions between participating women and health professionals, they consider that these actors would have a lot of potential (if they chose to) to support them in the multiple gaps they experience in front of the experiences of motherhood and their consequences in terms of mental health.

In this sense, it is pressing that, for the new public policies, the existing programs that are being carried out to provide women and their families in relation to motherhood, upbringing and health care, to listen more and involve the social participation of women's organizations, to effectively include the needs perceived by the populations they hope to benefit.

The institutions that train human talent in health in Colombia are beginning to introduce reflections on obstetric violence and respected childbirth, as aspects that deserve greater dissemination and implementation.

In addition, it is necessary to fully guarantee the right to communication in symmetrical terms, with a gender focus and empathy with the changes and uncertainties that women face regarding pregnancy, and in the experiences of their motherhoods, in which their own knowledge, perceptions and emotions are also valued, as well as their social and family contexts.

The right of women to live lives free of violence in terms of sexual and reproductive health, includes their relationship with professionals in health services, humanized attention in prenatal control, respected childbirth, post-partum control, and growth and development programs. Likewise, women themselves, whether they are mothers or not, should not be left out of the process. They demand warm, satisfactory, non-hierarchical, and intercultural care that includes both their sexual and mental health in a comprehensive manner.

Authors' contributions

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

Copyright

Editor
Rosamaria Giatti Carneiro
Associated editor
Maria Alice Garcia

Translator
Félix Héctor Rígoli

Submitted on
02/03/20
Approved on
10/27/20

References

1. Bourdieu P. La dominación masculina. Barcelona: Editorial Anagrama; 2000.
2. Ehrenreich B, English D. Por tu propio bien:150 años de consejos expertos a mujeres. Madrid: Taurus; 1990. v. 1a.
3. Goberna Tricas J. Autonomía, heteronomía y vulnerabilidad en el proceso de parto. ENE Rev Enferm. 2012; 6(6):71-8.
4. Sadler M. Despertando las metáforas que dormían en la ciencia. In: Quattrocchi P, Magnone N, editores. Violencia obstétrica en América Latina: conceptualización, experiencias, medicación y estrategias. Buenos Aires: EdunLa Cooperativa; 2020. p. vii–xxi.
5. Pimentel C, Rodrigues L, Müller E, Portella M. Autonomia, risco e sexualidades a humanização do parto como possibilidade de redefinições descoloniais acerca da noção de sujeito. Realis. 2014; 4(1):166-85.
6. Bedoya Ruiz LA, Agudelo Suárez AA. Relación de las mujeres en embarazo, parto y postparto (EPP) con los servicios de salud según la clase social. Rev Gerenc Politicas Salud. 2019; 18(36):1-28. Doi: https://doi.org/10.11144/Javeriana.rgps18-36.rmep.
7. Mattar LD, Diniz CSG. Hierarquias reprodutivas: maternidade e desigualdades no exercício de direitos humanos pelas mulheres. Interface (Botucatu). 2012; 16(40):107-19. Doi: https://doi.org/10.1590/S1414-32832012005000001.
8. Arguedas Ramírez G. La violencia obstétrica: propuesta conceptual a partir de la experiencia costarricense. Cuad Intercamb Centroam Caribe. 2014; 11(1):145-69. Doi: https://doi.org/10.15517/c.a..v11i1.14238.
9. McGarry J, Hinsliff-Smith K, Watts K, McCloskey P, Evans C. Experiences and impact of mistreatment and obstetric violence on women during childbearing: a systematic review protocol. JBI Database System Rev Implement Rep. 2017; 15(3):620-7.
10. Diaz-Tello F. Invisible wounds: obstetric violence in the United States. Reprod Health Matters. 2016; 24(47):56-64. Doi: https://doi.org/10.1016/j.rhm.2016.04.004.
11. Valdéz R, Arenas L, Rojas A, Sanchéz M. "If we're here, it's only because we have no money." Discrimination and violence in Mexican maternity wards. BMC Pregnancy Childbirth. 2018;18(1):244. Doi: https://doi.org/10.1186/s12884-018-1897-8.
12. Sens MM, Stamm AMNF. Percepção dos médicos sobre a violência obstétrica na sutil dimensão da relação humana e médico-paciente. Interface (Botucatu). 2019; 23:e180487. Doi: https://doi.org/10.1590/interface.180487.
13. Patiño J. El sistema de salud de Colombia: crisis sin precedentes. Rev Colomb Cir. 2013; 28(4):259-61.
14. Matud P, Carballeira M, López M, Marrero R, Ibáñez I. Apoyo social y salud: un análisis de género. Salud Ment. 2002; 25(2):32-7.
15. Berlanga S, Pérez R, Vizcaya M, Berlanga F. Satisfacción en la provisión de redes de apoyo social en grupos de acompañamiento a la maternidad. Enferm Glob. 2014; (33):18-32. Doi: https://doi.org/10.6018/eglobal.13.1.171441.
16. Fernández Moreno S. La violencia de género en las prácticas institucionales de salud: afectaciones del derecho a la salud y a las condiciones de trabajo en salud. Rev Gerenc Politicas Salud. 2007; 6(12):52-76.
17. Martín Gutierrez de Cabiedes M. Las nuevas tecnologías como fuente de apoyo social en la transición a la maternidad [tesis]. Madrid: Universidad Pontificia Comillas; 2018.

18. Maffesoli M. El tiempo de las tribus: el ocaso del individualismo en las sociedades posmodernas. Buenos Aires: Siglo Veintiuno Editores; 2004. v. 39.

19. Pulhez M. Mulheres mamíferas: práticas da maternidade ativa [dissertação]. Campinas: Unicamp; 2015.

20. Ramirez A. Ruta de atención integral en salud materno perinatal. Bogota: Ministerio de Salud y Protección Social; 2017. p. 1-38.

21. Badinter E. ¿Existe el amor maternal? Historia del amor maternal, siglos XVII al XX. Barcelona: Paidós; 1991.

22. Lerner G. The creation of feminist consciousness: from the middle ages to eighteen-seventy. Oxford: Oxford University; 1993.

23. O'Reilly A. Feminist mothering. New York: State University of New York Press; 2008.

24. Strauss A, Corbin J. Bases de la investigación cualitativa: técnicas y procedimientos para desarrollar la teoría fundamentada. Zimmerman E, traductor. Medellín: Universidad de Antioquia; 2004.

25. Kamberelis G, Dimitriadis G. Grupos focales. In: Denzin NK, Lincoln Y, editor. Métodos de recolección y análisis de datos. Barcelona: Gedisa; 2015. p. 494-532.

26. Rapley G, Murkett T. Baby-led weaning: helping your baby to love good food. London: Random House; 2008.

27. Pikler E. Moverse en libertad : desarrollo de la motricidad global. Madrid: Narcea Ediciones; 1984.

28. Petracci M, Sánchez V, Schwarz P, Mendez AM. La relación médico-paciente en la indagación académica contemporánea. In: Petracci M, Schwarz P, Rodriguez P, editors. Comunicación y salud: las relaciones entre médicos y pacientes en la modernidad tardía. Buenos Aires: Teseo; 2017. p. 105-81.

29. Bellón Sánchez S. La violencia obstétrica desde los aportes de la crítica feminista y la biopolítica. Dilemata. 2015; 7(18):93-111.

30. Castro Franco BE, Peñaranda Correa F. La comprensión de los significados de la maternidad: el caso de un programa de cuidado prenatal en un centro de salud en Popayán, Colombia. Salud Colect. 2011; 7(3):333-45.

31. Peñaranda F, Bastidas M, Escobar G, Torres N, Arango A. Educación para la salud: una mirada alternativa al modelo biomédico. Medellín: La Carreta Editores; 2010.

32. Foucault M. Vigilar y castigar: nacimiento de la prisión. Buenos Aires: Siglo Veintiuno Editores; 1985.

33. Diniz CSG, Niy DY, Andrezzo HFA, Carvalho PCA, Salgado HO. A vagina-escola: seminário interdisciplinar sobre violência contra a mulher no ensino das profissões de saúde. Interface (Botucatu). 2016; 20(56):253-9. Doi: https://doi.org/10.1590/1807-57622015.0736.

34. Sadler M, Santos MJ, Ruiz-Berdún D, Rojas GL, Skoko E, Gillen P, et al. Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. Reprod Health Matters. 2016; 24(47):47-55. Doi: https://doi.org/10.1016/j.rhm.2016.04.002.

35. Moreiras Sena L, Dalcanale Tesser C. Violência obstétrica no Brasil e o ciberativismo de mulheres mães: relato de duas experiências. Interface (Botucatu). 2017; 21(60):209-20. Doi: https://doi.org/10.1590/1807-57622015.0896.

36. Lagarde M. Claves feministas para el poderío y la autonomía de las mujeres. Managua: Editorial Puntos de Encuentro; 1998.

37. Rocha-Acero ML, Socarrás-Ronderos F, Rubio-León DC. Prácticas de atención del parto en una institución prestadora de servicios de salud en la ciudad de Bogotá. Rev Fac Nac Salud Publica. 2019; 37(1):53-65. Doi: https://doi.org/10.17533/udea.rfnsp.v37n1a10.

38. Vallana Sala VV. Parirás con dolor, lo embarazoso de la práctica obs-tétrica: discursos y prácticas que naturalizan la violencia obstétrica en Bogotá [maestría]. Bogotá: Facultad de Ciencias Sociales, Pontificia Universidad Javeriana; 2016.

39. Chinchilla Alvarado L. El parto humanizado en Costa Rica como práctica y discurso contrahegemónico: primeros acercamientos teórico-conceptuales. In: 7a Jornadas de Investigación, Acción Social y Docencia; 2017; San José. San José: Universidad de Costa Rica; 2017. p. 18-22.

40. Herrera Vacaflor C. Obstetric violence: a new framework for identifying challenges to maternal healthcare in Argentina. Reprod Health Matters. 2016; 24(47):65-73. Doi: https://doi.org/10.1016/j.rhm.2016.05.001.

En la contemporaneidad, las madres encuentran en las redes sociales virtuales posibilidades para contrastar y cuestionar las prácticas institucionalizadas de los profesionales de salud. Este artículo tiene como propósito entender las percepciones de madres colombianas participantes de una red virtual sobre maternidad, respecto a sus relaciones con los programas de salud enfocados en el embarazo, parto, maternidad y crianza. El análisis se realizó a través de la teoría fundamentada, a partir de un (1) grupo focal y 17 entrevistas en profundidad a mujeres integrantes del grupo y profesionales de la salud. Se encontraron grandes frustraciones frente a los programas y profesionales, falta de apoyo y conocimientos para afrontar la llegada del nuevo bebé. Se concluye la urgencia de que los programas incorporen las necesidades percibidas por las mujeres para un mayor apoyo frente a la salud física y mental.

Palabras clave: Maternidad. Embarazo. Redes sociales. Promoción de la salud y comunicación.

Na contemporaneidade, as mães encontram nas redes sociais virtuais possibilidades de contrastar e questionar as práticas institucionalizadas dos profissionais da saúde. O objetivo de este artigo foi compreender as percepções de mães colombianas participantes de uma rede digital de maternidade, sobre suas relações com programas de saúde focados na gravidez, parto, maternidade e criação dos filhos. A análise foi realizada usando a Teoria Fundamentada em Dados obtidos de um grupo focal e 17 entrevistas em profundidade com mulheres integrantes do grupo e profissionais da saúde. Grandes frustrações foram encontradas frente aos programas e profissionais, falta de apoio e conhecimentos para enfrentar a chegada do novo bebê. Conclui-se na urgência que os programas incorporem as necessidades percebidas pelas mulheres, para dar um maior apoio frente à saúde física e mental.

Palavras-chave: Maternidade. Gravidez. Redes sociais. Promoção da saúde e comunicação em saúde.