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ORIGINALS

Hierarchical relationships between mother, family, and Health Services in the context of prenatal care

Relaciones jerárquicas entre madre, familia y Servicios de Salud en el contexto del control prenatal

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ABSTRACT:

Objective: Describe the interactions that pregnant women have with their families and the prenatal care program to construct meanings about maternal health.
Method: Qualitative study, the method used was grounded theory. In-depth interviews were conducted; the information was analyzed using the constant comparative method. The substantive codes were recorded in an Excel® workbook (open coding) and were then assembled in an explanatory manner by applying the paradigmatic model, thus establishing the relationships between categories and subcategories (axial coding). Finally, the categories and subcategories found were refined, integrating the data, and identifying the central category (selective coding).
Results: A central category emerged: maternal health care characterized by hierarchical relationships between the mother, the family and health services and three interpretive categories contributing to the central category.
Conclusions: Interactions with prenatal care and the construction of meanings by pregnant women and their families about maternal health in the context of the relationships arising from the provision of health services are defined by the role assumed by the pregnant woman as a receiver of information and a follower of orders issued by them. Pregnant women and their families in their interaction with health service providers (prenatal care) do not have the opportunity to express their opinions about health care during pregnancy.

Key words: Maternal Health; Pregnant Women; Prenatal Care; Community-Institution Relations.

RESUMEN:
Objetivo: Describir las interacciones que tienen las mujeres gestantes con sus familias y el programa de control prenatal para la construcción de significados sobre salud materna.
Método: Estudio cualitativo, el método utilizado fue la teoría fundamentada. Se realizaron entrevistas a profundidad; el análisis de la información se hizo por medio del método comparativo constante. Los códigos sustantivos fueron consignados en un libro de Excel® (codificación abierta), posteriormente fueron ensamblados de manera explicativa aplicando el modelo paradigmático, estableciendo así las relaciones entre categorías y subcategorías (codificación axial). Finalmente, se hizo el refinamiento de las categorías y subcategorías encontradas, integrando los datos e identificando la categoría central (codificación selectiva).
Resultados: Emergió una categoría central: *cuidado de la salud materna caracterizado por relaciones jerárquicas entre la madre, la familia y los servicios de salud* y tres categorías interpretativas aportantes a la categoría central.
Conclusiones: Las interacciones con la atención prenatal y la construcción de significados de las gestantes y sus familias sobre la salud materna en el contexto de las relaciones surgidas en la prestación de los servicios de salud están definidas por el rol asumido por la gestante como receptora de información y cumplidora de ordenes emanadas por estos. Las gestantes y sus familias en su interacción con los prestadores del servicio de salud (control prenatal) no tienen la oportunidad de expresar sus opiniones acerca del cuidado de la salud durante el embarazo.

Palabras Clave: Salud Materna; Mujeres Embarazadas; Atención Prenatal; Relaciones Comunidad-Institución.

INTRODUCTION

Motherhood throughout the history of humanity has been inherent to women and their femininity, it has been established as a mark to which women are inclined, being also what is socially expected of them. Throughout history motherhood went from being the primary axis for society to being in a position of subordination of women in relation to men, which was framed in the patriarchal society, and has been maintained, even today [(1)].

Pregnancy, motherhood, and birth mean a major change in different aspects of a woman's life and that of her family. To ensure that these are healthy and pleasant, it is essential that women and their families acquire knowledge, skills and abilities that help them cope with the different physical, emotional and lifestyle changes. This process has been culturally carried out within the family; women have learned from the experience of their mothers and other pregnant women how to care for pregnancy [(2,3)]. Each culture defines and classifies pregnancy care according to its vision of life, which are transmitted and perpetuated over time.

Various studies have found cultural behaviors that reveal care practices during pregnancy, with which, for example, the future mother abstains from consuming foods prohibited by her culture, as well as avoids performing some household chores that could interfere with the proper development of pregnancy and childbirth. Based on these cultural care practices, the health system and professionals must develop intercultural skills and competencies that allow them to recognize, harmonize and negotiate the particularities of each social group [(4)].

On the other hand, prenatal care is essential to ensure the progress of pregnancy, allowing for a healthy birth without negative impact on maternal health, and encompassing the approach to psychosocial aspects, as well as educational and preventive activities [(3)]. The effectiveness of health care during pregnancy, childbirth

and postpartum is a global challenge, since there must be appropriate follow-up during this period to achieve comprehensive care for pregnant women [5].

In this sense, proposals such as the humanized birth model seek to combat failures in prenatal care and improve the experience of motherhood, which includes the patriarchal and hierarchical relationships established by tradition between health professionals and pregnant women [6]. For the World Health Organization (WHO), maternal care should be a positive experience where the physical and sociocultural normality of the woman is maintained, and which provides her with a healthy pregnancy for the benefit of the mother and the newborn [7].

In this context, the Pan American Health Organization (PAHO) states that social, economic, demographic, and cultural contexts influence prenatal care, so that health care must articulate the care processes to advance towards a comprehensive understanding of prenatal care situated in the context of the pregnant woman [8]. For its part, humanized care is understood as that which seeks to recognize the pregnant woman as the axis of prenatal care and protagonist of the process, maintaining a permanent dialogue and links between the pregnant woman, the family and the health system, which provide the possibility of incorporating cultural diversity in the construction of prenatal care, vindicating ancestral knowledge and facilitating the participation of women in the care and attention of their own health.

In turn, prenatal care is conceived as a set of activities carried out by the pregnant woman. These involve a stipulated number of medical consultations and with other health professionals received by the pregnant woman in a health institution, with the purpose of monitoring the progress of the pregnancy, early detection of risks, preventing possible complications and preparing the woman for childbirth and raising her child [9].

In accordance with this, the Ministry of Health, and Social Protection of Colombia through the Comprehensive Health Care Route for the Maternal-Perinatal Population (RIAMP) seeks to contribute to the promotion of health and the improvement of maternal and perinatal health outcomes, through comprehensive care, including coordinated and effective action by the State, society, and the family on the social and environmental determinants of health inequities [10]. This route is oriented to the development and strengthening of the potential and capabilities of pregnant women and women in the postpartum period, families, communities, organizations and networks for the promotion of individual and collective health, risk management and the positive transformation of different environments; in order to contribute to the development of individual and collective autonomy, the determination of lifestyles and the guarantee of the right to health and the development of capacities for health care in women, mothers and unborn children [10].

In this context, the participation of women and their families in prenatal care activities creates a bond with health professionals, facilitating the exchange of experiences, the promotion of self-care, the exchange of information, the collective construction of knowledge and harmony between scientific and popular knowledge [11, 12]. In this sense, it is important to know the type of interaction established between the pregnant woman and her family with the health services (prenatal control); since the success of prenatal care will depend largely on this. The established interaction can function as a fundamental instrument to create shared care, facilitating, through identification and

cooperation, progress in the gestation process and the improvement of the living conditions of pregnant women and their unborn child, extending prenatal care beyond the transmission of instructions and knowledge by health personnel towards the empowerment and autonomy of women in decision-making about maternal health. The present study sought to describe the interactions that pregnant women have with their families and the prenatal care program to construct meanings about maternal health.

METHOD

A qualitative study was conducted, the method used for the analysis of the information was that of grounded theory from the straussian perspective. The grounded theory is based on the constant comparative method for the analysis of the data, by which the researcher codes and analyzes the data simultaneously, progressively developing theoretical ideas that arise and are related to the data [13].

The research was carried out in the city of Montería in 2022. To collect information, a strategy was used to conduct semi-structured interviews with pregnant women and some members of their families, emotional partners, and mothers, to describe the interactions that pregnant women and their families have with the prenatal control program for the construction of meanings about maternal health. Potential participants were contacted at the different offices of the State Social Enterprise (E.S.E) in the city of Montería, to whom an invitation was made to participate in the study. After acceptance, depending on the availability of time and the choice of the participants, the interview was scheduled at each of their homes.

For the selection of participants, a snowball or avalanche sampling was initially used, moving on to a theoretical sampling. The criteria for participation were that they were pregnant women of legal age, at any gestational age, affiliated with the General Social Security System in Health, from all socioeconomic strata (high, medium, low), who attended the prenatal control program of an E.S.E in the city of Montería, as well as family members of these pregnant women, among whom could be the spouse, mother, father and/or caregiver or other people who were part of their family circle, who lived and interacted with them for their care.

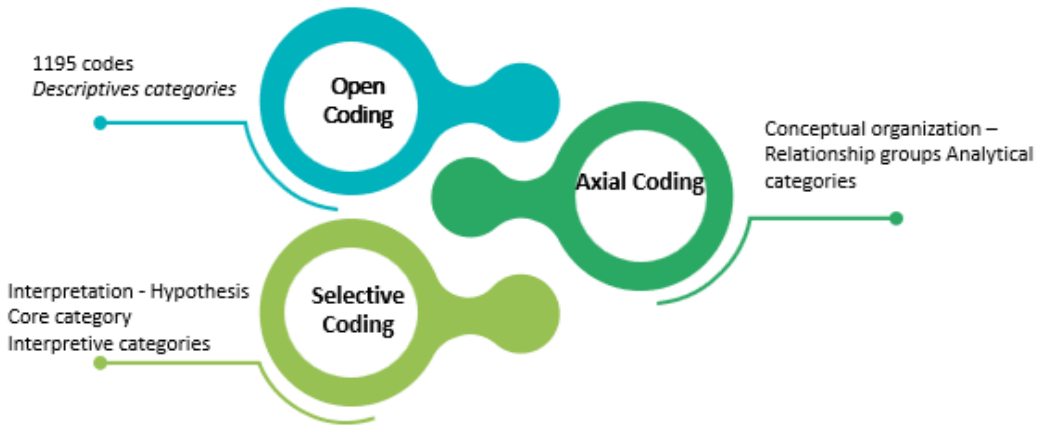
Semi-structured interviews were conducted after interaction with the participants at the different E.S.E. locations and later an appointment at their homes, with the purpose of carefully and step-by-step preparing the experience and construction of meanings about maternal health based on interactions with prenatal care. The interviewer was a nurse - professor with a master's degree in nursing and a doctoral student in Public Health. A total of 16 participants were interviewed, with whom information saturation was reached, which led to the presentation of the categories presented in this article (8 pregnant women and their families). The interviews were recorded with prior authorization and were later faithfully transcribed to analyze the data, which were compared with the informants and with the researcher's field notes. The interviews lasted on average 60 minutes.
Once the interviews were transcribed, the data analysis process began using the TF methodology from the straussian perspective. In the first stage of analysis, the interview transcripts were analyzed line by line, identifying the substantive or interpretive codes, which were recorded in an Excel® workbook (open coding). Open coding was not limited to establishing labels, but also an interpretive coding was

developed, in such a way that each fragment of the stories that emerged in the microanalysis was assigned an interpretive code that contributed to avoiding the loss of the meaning of what was expressed by the participant in said fragmentation, always maintaining the link between the code and the fragment that originated it. From this stage, 1,195 interpretive codes emerged. As a result of the analysis of the first coding, groupings of interpretations were identified, giving rise to the first categories called descriptive in this model (Figure 1).

Subsequently, in the second stage, the codes were assembled in an explanatory manner in accordance with the objective of the research, applying the paradigmatic model, thus establishing the relationships between categories and subcategories (axial coding). In this coding, the description of the data was replaced by a conceptual organization of the same, reflecting the existing relationships between the content and the structure of each category. In the axial coding, the groups of relationships that contained the codes obtained in the interpretative process could be established. These grouped relationships gave rise to the analytical categories (Figure 1).

The last step of the analysis was the refinement of the categories and subcategories found, integrating the data, and identifying the central category (selective coding). At this stage, the statements, dimensions, and properties of the categories that emerged were specified in the form of hypotheses that indicate the prior construction of reality, as well as during the interviews between the participants and the researcher, giving rise to the interpretive categories (Figure 1). These last categories have the capacity to explain and understand the reality of the interactions of pregnant women and their families with prenatal care.

Figure 1: Data analysis.



Source: Own elaboration.

The interviews were conducted after the informed consent form was signed. The identity of the participants was protected by using codes to record the information. The transcription of the interviews did not contain personal or private data of the participants and was carried out by an expert transcriber and subsequently verified by the research team. The researchers and the participants did not have any type of relationship before the execution of the research, so there was no conflict of interest.

RESULTS

The ages of the pregnant participants ranged from 18 to 43 years and that of their family members ranged from 30 to 63 years. The pregnant women, as well as the family caregivers, were mostly housewives (Table 1).

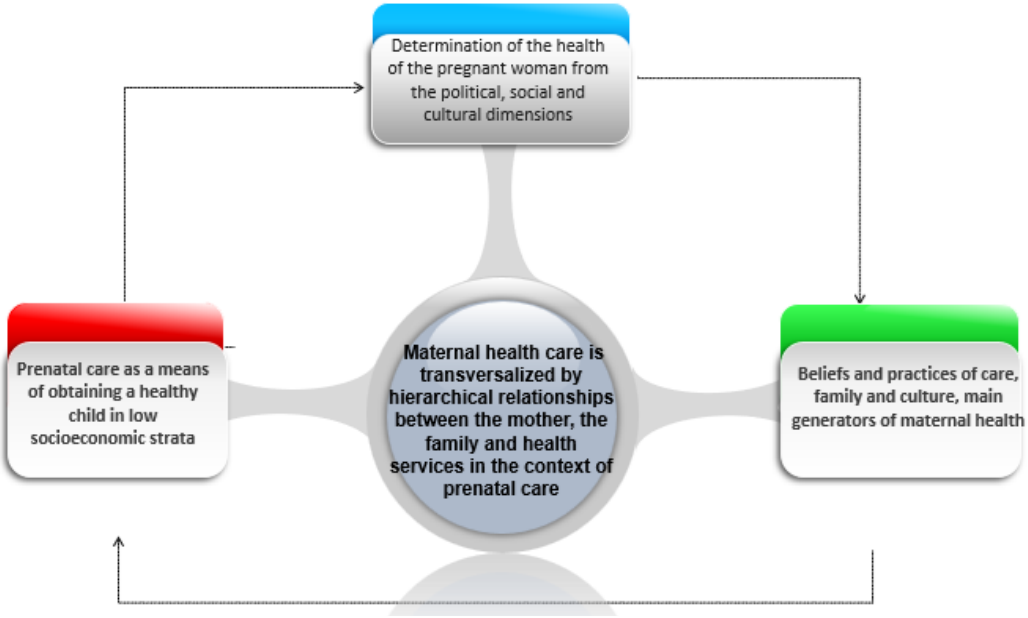
Table 1: Demographic data of participants.

Number	Age	Type of participant	Occupation
1	23	Pregnant woman	Student
2	43	Pregnant woman	Housewife
3	27	Pregnant woman	Housewife
4	18	Pregnant woman	Student
5	40	Pregnant woman	Housewife
6	36	Pregnant woman	Housewife
7	25	Pregnant woman	Housewife
8	28	Pregnant woman	Housewife
9	30	Family member (spouse)	Employee
10	46	Family member (spouse)	Self-employed worker
11	62	Family member (mother)	Housewife
12	42	Family (Sister-in-law)	Housewife
13	52	Family member (sister)	Community mother
14	63	Family member (mother)	Housewife
15	33	Family member (sister)	Housewife
16	38	Family member (sister-in-law)	Housewife

Source: interviews

In the analysis process, a central category emerged called “maternal health care characterized by hierarchical relationships between the mother, the family and health services”; likewise, three categories contributing to the central category were identified: “determination of the health of the pregnant woman from the political, social and cultural dimensions”, “prenatal control as a means to obtain a healthy child in ”, “beliefs and practices of care, family and culture as the main generators of maternal health” (Figure 2).

Figure 2: Core category and interpretive categories.



Source: data analysis.

For the participating women and families, the prenatal control program is identified as a useful and important service for pregnant women from low socioeconomic strata who do not have the opportunity to access specialized health services in a private manner. In prenatal control, participants recognize the provision of health services for pregnant women such as medical consultations, laboratory tests, and receive necessary recommendations to maintain their health and that of their unborn child.

"Well, honestly, it has been the best it could be, I think that comes from the government, right? What the government has stipulated for first-time mothers, for mothers from stratum 1-2" (EF1C80).

"I come back and say the economic issue, there are people who do not have the resources to go and hire a private doctor who pays so much money" (EF1C87).

"I am always aware of keeping appointments, because it is a process that not only, I need but the baby too" (EG1C81)

"They have sent me for tests, ultrasounds, and… they also sent me for a dental appointment, a psychology appointment, a nutrition appointment, and a gynecologist appointment" (EG3C81)

"Well, because they are very attentive, they call her and she also gave me my number and they call me to remind me of the appointment, I am attentive about that, in case she does not answer, there is mine and I immediately contact her" (GFF97)

"I am always aware of keeping appointments, because it is a process that not only, I need but the baby too, all the tests they send me, the medications they send me to take too" (EG1C80).

Likewise, pregnant women and their families recognize that the greatest benefit received from the program is having a healthy child. In such a way, it is the responsibility of the pregnant woman to attend and comply with the instructions given in it.

> *"Well, for me, I would say that this importance is perhaps not seen at this moment during pregnancy, but at the moment when the child is born, that it is a healthy child, that it is a child with all its little fingers, its little hands, that it is a completely healthy child" (EG1C53)*

> *"He is always very anxious, he always goes with great desire for the doctor to tell us how the baby is, his anxiety is regarding the baby, because as a father he always wants to be told that his child is doing well, that everything is going well" (EG1C76).*

> *"Because through the control, this, we know how our baby is doing, what is that called? From the, when they do… oh, to see how the baby is doing. The Doppler, we know how it is, what vitamins, what calcium, how the baby is developing, the tests they send us" (EG2C68)*

The results of the research reveal that maternal health care is intersected by hierarchical and distant relationships between the mother, the family, and the health services. In this relationship, the pregnant woman takes on the role of recipient of information and the commitment to obey and fully comply with the orders and recommendations made by the health services (prenatal care) and their families. In this sense, it is the responsibility of the pregnant woman to comply with all the instructions given by them.

> *"Well, until now my check-ups have only been appointments" (EG3C76).*

> *"I have been to the check-up so many times, they ask me for the tests, they review them, they tell me everything went well, that if they see something altered, they send me things to fix it, but they don't tell me anything else and I do what they tell me" (EG8C74).*

> *"They have sent me for tests, ultrasounds, and… they also sent me to a dental appointment, a psychology appointment, a nutrition appointment, and a gynecologist appointment. I do everything they send me to do." (EG3C80).*

> *"I am very attentive, and I do everything they tell me to do during check-ups. I am attentive to the warning signs as they tell me during check-ups, for example if I feel any pain that is not normal, if I have a fever or something, I am very attentive to that." I do what they tell me. (EG1C42).*

The pregnant woman does not have adequate interaction with the personnel responsible for health care within the prenatal control program, consequently, she does not express her experiences and perceptions related to her gestation process. This distant relationship between the pregnant woman and the health services does not favor the dialogue of knowledge established by national public policy.

"Yes, even the doctor on duty scolded me last week, because I forgot, I forgot to tell the gynecologist about my sugar problem, because I thought he had seen the tests, as he asked me to, meaning that he did not review them and did not ask me anything during the consultation" (EG465).

"The doctor attended me; the doctor gave me that little bit of things that I did not understand what it was, even the gestures, the names are different. She didn't explain anything to me, I was really confused" (EG5C21).

"Well, what can I say? Without them asking me, I tell them how I feel myself. They never ask me how I feel. It's up to me to tell them without them asking me, but they don't tell me anything either." (EG5C71)

"The doctor says something that suddenly, it's like, sometimes with a doctor, instead of encouraging people, women, sometimes they come out with rudeness" (EF2C63).

Similarly, the relationship established by the pregnant woman with her family regarding maternal health care is based mainly on her following the recommendations given by her family, which guarantees an adequate pregnancy and the birth of a healthy child. Likewise, the family is responsible for supervising that the pregnant woman attends and complies with the instructions given in each of the prenatal check-ups.

"She should only go to medical appointments and be at home, and she should be in her room, resting, taking her respective pills, that is what we do, that is our care and that is what we recommend, and she does it" (EF1C14).

"The pregnant woman should control her food, so far there has not been so much excess food for her, little fat, eh, low salt, eh, a little fruit and a little so that she does not gain weight and become obese" (EF2C14).

"And my mother and my brothers have always told me "Be careful, make sure your feet don't swell too much", because it's not normal for them to swell so early, I'm always aware of those little things and they give me those recommendations, I'm always aware and I do what they tell me" (EG1C43).

"Well, my father takes care of me in the sense that he tells me that I must eat a lot, he wants me to eat every moment, so that his grandson doesn't get malnourished. I mean, when 12 or 12:30 comes around, I have the habit of always serving and staying last, he says to me, "Yeah, and yours, aren't you going to eat?" They're always watching to make sure I eat" (EG3C35)

The pregnant woman's family is the main organizer and provider of care for the future mother and her child. It is within the family that maternal health is sustained; it supports and supervises the pregnant woman in the care practices that must be applied throughout the gestation process. The family assumes responsibility for feeding the mother, as well as providing her with the necessary affection and protection, and is also responsible for supervising attendance at prenatal care appointments. The care and support of family members guarantees good treatment, good interaction, and good relationships, as well as a healthy pregnancy.

"Well, I think that the support of the family, I think it is very important because during pregnancy sometimes we feel like… like we cannot do certain things, we restrict ourselves from doing certain things, but with that constant support from the family there" (EG1C51).

"And no, as for my family helping me, yes, because even though I have already had other children, they are super happy with the baby my aunt takes care of me a lot, eh, my sisters, my husband, and the truth is that I have had a lot of support from them" (EG7C42).

"At the family level I also have the support of my husband, I live with my husband and my daughter, my brothers live nearby, my rest of the family is in Venezuela, but my brothers are there who are a support, they do support me, they are there for me" (EG5C38).

"My family does take care of me with the pregnancy, yes, they are aware of me, if I crave something they give it to me, that, if I want this, what do you want to eat and they are aware of my food that it is a good meal, my husband is very aware of always having my food" (EG4C47).

"First of all, not to make her angry, not to fight with her, to treat her as best as possible so that she feels good during this pregnancy, and it is not a risky pregnancy. So that suddenly, as there are so many, nowadays sometimes the mistreatment of the pregnant woman suddenly shocks her, her blood pressure can go up, she suddenly becomes angry, and the baby can come out" (EF2C31)

In this sense, families and pregnant women consider nutrition to be the most important care during pregnancy and as a determining factor for the health of the unborn child, without giving it the same importance as a generator of health for the mother. For the participants, the main benefit of nutrition during pregnancy is to have a healthy newborn with a good birth weight. For her part, the pregnant woman has the responsibility of consuming the necessary foods for this purpose.

"Well, mainly I am taking great care of my diet. Because during pregnancy I have had to give up several foods that I used to eat a lot, such as sugars, soft drinks, sweets, I have had to give all of that up a bit, reduce it, fats… because I need to have a balanced diet for the sake of the girl" (EG1C7).

"Well, for me, I would say that we are not seeing that importance during pregnancy, but at the moment the child is born, that it is a healthy child, that it is a child with all its little fingers, its little hands, that it is a completely healthy child" (EG1C53)

"Because I say that, if I eat well, if I have a good diet, my baby receives amniotic fluid, receives good nutrition, if I eat poorly, the baby is not well nourished, it cannot be a child that is not healthy but sick" (EG2C63)

"And she is doing this pregnancy even with hunger because all that causes it for the health of the baby, so that it is not born malnourished. That is why I always

tell her, Arcelys, do not stop eating, if something causes it, eat it, that is for the boy or the girl, he or she will receive it" (EF3C55)

In turn, society and culture also play a very important role in maternal health care, establishing a large part of the care practices carried out by the pregnant woman and her family during pregnancy. Family beliefs and cultural care practices are recognized as vital to achieving an adequate pregnancy. For the participants, the application of these practices guarantees that the mother goes through a pregnancy without complications and that her child is born healthy and well nourished. Since the mother of the pregnant woman is the person with the most experience in the family in pregnancy care, it is on her that the responsibility of maternal health care falls. The results reveal that these dimensions (social and cultural) that surround the pregnant woman do not interact with the political context in charge of guaranteeing maternal health.

"I tell her not to bathe too late, she can bathe even at 2 in the afternoon, from then on not, bathing hurts her because she catches a cold, bathing late is bad because of the cold" (EF3C13).

"Because it takes longer to give birth, to have the baby, so for that cold she must take soda baths, or use coconut water and add soda, with a little spoon, so that the cold goes away more. She must take baths, pour warm water on herself from here down but she never gets that cold because many people don't pay attention to you, they say it's old people's things" (EF6C21).

Yes, her mother, that is to say my mother-in-law because we live in her parents' house, is the one in charge of that issue, she automatically offered herself to me first because she knows what it's like, I tell you, she was a mother 3 times and she knows what it's like with the belly and what it needs" (EF1C36).

"My mother prepares my meals and takes good care of me, she tells me what to do, my whole family has helped me to lead a healthy life during pregnancy" (EG1C31).

"At the check-up they don't tell me anything that my family tells me, there they only tell me the pills and the tests that I have to take and the appointments that I have to make" (EG6C28).

"The doctor who treats me has never asked me about that, she doesn't know how I take care of myself the way my mother and my mother-in-law take care of me" (EG8C25).

DISCUSSION

Regarding the objective of the study, the results reflect the interactions that pregnant women have with their families and with the prenatal control program. Regarding the central category, the participants' stories describe the establishment of a hierarchical relationship between health services and the pregnant woman; these results go against international and national recommendations on prenatal care. The WHO states that the experience of the pregnant woman with the provision of health services and

the type of relationship established with professionals can transform traditional prenatal care, actively involving the pregnant woman, the family, and the community [14].

Therefore, communication and the type of relationships built between health professionals and the pregnant woman must become a component of building shared value; with this and mutual recognition, progress can be made in prenatal care towards better living conditions for the pregnant woman, beyond the mere transmission of information and knowledge. Communication is part of the essential elements of health education to promote health promotion, as well as a characteristic component of social life that leads us to understand each other, resolve differences and work together for a common goal [15,16].

Similarly, the results of the research reveal the deficiency of health services (prenatal care) in carrying out activities and guidance that generate empowerment, increased autonomy and decision-making capacity of pregnant women, seeking to help them exercise their personal freedom in their reproductive process. To this end, it is essential to make a continuous effort to educate throughout pregnancy, allowing each woman, together with the health professionals who assist her, to make informed and autonomous decisions among the options available in each situation [17].

For its part, the global strategy for the health of women, children and adolescents seeks to transform health care, including maternity services, into a model that promotes female empowerment and favors positive results in childbirth, both physically and emotionally for women, babies and their families [18]. To achieve this, the design and provision of quality prenatal care services must go beyond ensuring survival during pregnancy and childbirth, allowing women to actively participate in their own care, a key aspect of their empowerment [19].

In this sense and based on these premises, the Colombian Public Health policy established the comprehensive maternal-perinatal health care route as a mandatory tool throughout the country, and establishes the necessary conditions to guarantee health promotion, disease prevention and the generation of a culture of care for maternal health. The route proposes the construction of an equal intercultural relationship and prenatal care based on a fluid dialogue of knowledge between the pregnant woman, her family, and the health professionals responsible for care, in such a way that the pregnant woman's capacities to achieve and maintain adequate maternal and perinatal health are strengthened and enhanced. Thus, with this policy, the conditions under which prenatal care must be provided to pregnant women throughout the country are determined without distinction of contexts and/or particularities surrounding each pregnant woman [11].

However, in health services, prenatal care continues to be referred to as “prenatal control” with the connotation of “control, follow-up and monitoring of pregnant women.” In this sense, the research reveals a relationship between health service (prenatal control) and patient characterized by a pregnant woman who is not recognized as having autonomy in decision-making regarding the care of her pregnancy and her health, with a function limited to receiving and following orders issued by health professionals. These hierarchical relationships in prenatal care nullify the possibility of a dialogue of knowledge as recommended, since women are not given the opportunity to contribute their perceptions in the experience and in the construction of meanings. It

also restricts their freedom and autonomy in decision-making, as well as their ability to empower themselves in the care of their pregnancy and their health.

Contrary to the findings, the dialogue of knowledge allows exploring sociocultural beliefs and practices in pregnancy, childbirth and postpartum at individual, collective and family levels, giving meaning to community-collective thinking [17]. The dialogue of knowledge is used in the context of interculturality (in the provision of health services) and through this, achieve relationships between health services and pregnant women characterized by warm ties and humanized treatment.

In agreement with the results, Yepes and collaborators affirm that in the General Social Security System in Health (SGSS) of Colombia, the fundamental right to health is reduced to membership in it with a series of benefits that depend on the market where competition between the different insurers and the state converges [18]. In this, health care and user participation are established from the national level through norms, laws, and protocols, presented in a fragmented manner at the different levels of care, with a hierarchy and taxative bureaucracy that permeates the exercise of the right to health [19,20].

Likewise, the SGSSS is made up of a series of institutions of different administrative order where the information is equally fragmented, impregnating the relationships between the different actors of the system, where the decisions of health care are not subject to the needs of the patients and/or users, on the contrary, they are governed by the personal, professional and institutional nuances of the actors of the system [19], which has led in a taxative manner to establish this type of hierarchical and power relationships that prevent an adequate interaction between the health service, the professionals and the users.

With respect to the interpretive categories, the results reveal the meaning constructed by the participants with respect to prenatal care. In this sense, it is perceived only as a means for poor women to obtain medical appointments and examinations that allow them to bear a healthy child, but not as the context that allows them to strengthen their prenatal education and decision-making power as a woman, respecting their experiences and beliefs, reconciling cultural beliefs and scientific evidence on pregnancy and childbirth [6].

The interaction between the pregnant woman and her family regarding health care during pregnancy and that of the unborn child is determined by their culture and beliefs. It is the family that decides which care activities the pregnant woman should perform and which risky activities she should avoid. This care is configured within the worldview, traditions and norms related to health care acquired by the family and converted into care practices [21]. These cultural nuances make the experience of pregnancy unique, significant, and transcendent. The influence of mothers, grandmothers, mothers-in-law and in general of the women of the family has transmitted and preserved these practices during pregnancy, making the family the first support network for the pregnant woman [22]. In this sense, Ulloa and Muñoz highlight the work of the women of the family, especially the mothers as caregivers, transmitters of knowledge, beliefs, practices, and advice, which the woman puts into practice during the gestation period [4].

For their part, Miranda and Castillo found that pregnant women are positively influenced by their mothers, partners, and families in general to attend prenatal check-ups. This could be used by health professionals to reinforce pregnancy care practices from the family, especially from the women who surround the pregnant woman and who can represent a care network for her and for the unborn child [23].

It is imperative to improve the interaction between health professionals and pregnant women during the provision of prenatal care services. While this qualitative study, focused on a specific sample, has limitations that prevent generalization of its findings to the entire population, the results offer valuable insights into similar dynamics in other prenatal care settings. Therefore, it is crucial to conduct future research in diverse geographical and cultural settings to gain a more complete understanding of the realities of prenatal care both nationally and in Latin America.

CONCLUSIONS

Interactions with prenatal care and the construction of meanings by pregnant women and their families about maternal health in the context of the relationships that arise in the provision of health services are defined by the role assumed by the pregnant woman as a receiver of information and a follower of orders issued by them. Pregnant women and their families in their interaction with health service providers (prenatal care) do not have the opportunity to express their opinions about health care during pregnancy. Thus, a hierarchical and distant relationship has been established for maternal health care, with health institutions at the top of this relationship and the pregnant woman and her family at the bottom; each of the actors carries out activities aimed at protecting the health of the pregnant woman on their own.

Although Colombian public policy provides for prenatal care based on a dialogue of knowledge between health services, pregnant women and families, strengthening the autonomy and empowerment of women in decision-making for the benefit of their health, prenatal care continues to be provided in a traditional biomedical manner and not focused on women as the protagonists of the prenatal process and their needs; which reveals the lack of preparation of the personnel who provide health services in terms of holistic care of pregnant women as well as the failures in the implementation of the policy. The proposed Dialogue of Knowledge would allow for a harmony between the medical knowledge of health services and popular knowledge on maternal health care, which would provide a real approximation of the situation of pregnant women and their families, as well as the contextualization of the representations.

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