PRENATAL HEALTH BEHAVIORS IN MEXICO

AND

MASS COMMUNICATION/EDUCATION STRATEGIES FOR IMPROVEMENT

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TABLE OF CONTENTS

SUMMARY 1

I. OVERVIEW 2

A. BACKGROUND 2

B. SPECIFIC OBJECTIVES 4

1. Phase I, Ethnographic 4

2. Phase II, Survey 4

3. Phase III 4

C. RESEARCH QUESTIONS 5

II. RESEARCH METHODOLOGY 6

A. PURPOSE OF THE ETHNOGRAPHIC AND SURVEY PHASES . . . 6

1. Ethnographic Phase 6

2. Survey Phase 6

B. SAMPLE SELECTION 7

1. Criteria 7

2. Communities 7

3. Women 8

4. Sample Size 9

5. Human Subjects Protection 9

C. INSTRUMENT DEVELOPMENT AND DATA COLLECTION 10

1. Ethnographic Phase 10

2. Survey Phase 11

D. DATA ANALYSIS 12

1. Ethnographic Phase 12

2. Survey Phase 12

E. PROBLEM AREAS 13

III. RESEARCH RESULTS 13

A. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS 14

B. UTILIZATION PATTERNS OF PRENATAL CARE SERVICES . . 17

1. Initiation of Care Patterns 17

2. Use of Formal and Informal Prenatal Care Services 20

4. Obstacles to Use of Services 23

5. Content of First Prenatal Visit 24

6. Use of Pregnancy-Related Sources of Information 26

7. Perceptions of Prenatal Care 28

C. PREGNANCY RELATED BELIEFS AND BEHAVIORS 29

1. Stages of Pregnancy 29

2. Concepts of Risk 29

3. Weight and Weight Gain 32

4. Anemia 33

5. Food and Food Habits 33

6. Stress, Rest and Activity 35

D. COMMUNICATION PATTERNS 35

IV COMMUNICATION PHASE 39

A. METHODOLOGY 39

B. CAMPAIGN MESSAGES 41

C. CHOICE OF MEDIA 43

V. CONCLUSIONS AND RECOMMENDATIONS 46

A. NEED FOR INFORMATIONAL MATERIALS TO IMPROVE PREGNANCY OUTCOME 46

B. THE NEXT STEP 47

C. DISSEMINATION OF RESEARCH FINDINGS 48

D. EVALUATION OF THE ICRW PROGRAM IN RELATION TO THIS PROJECT 49

REFERENCES 51

Table 1

NUMBER OF WOMEN AND

COMMUNITIES PARTICIPATING IN STUDY 9

Table 2

THE SOCIO-DEMOGRAPHIC

CHARACTERISTICS OF THE STUDY POPULATION 15

TABLE 3

SOCIO-DEMOGRAPHIC CHARACTERISTICS BY INITIATION PATTERN

. 19

TABLE 4

FREQUENCY OF USE OF FORMAL AND INFORMAL HEALTH CARE SERVICES

BY EARLY, LATE, AND NON-INITIATOR GROUPS 22

TABLE 5

CONTENT OF FIRST PRENATAL VISIT 25

TABLE 6

RANKED ORDER FREQUENCY DISTRIBUTION OF USE

OF INFORMATION SOURCES

BY EARLY, LATE AND NON-INITIATORS 27

TABLE 7

Sources of Health Information 36

TABLE 8

GENERAL COMMUNICATION PATTERNS 38

SUMMARY

This project used anthropological and survey research methods to obtain baseline information from 491 pregnant women to design and test public mass media materials for improving health-related behaviors during pregnancy in the U.S.-Mexican Border population. Factors measured were food beliefs, utilization patterns of prenatal care, and sources of health information. Previous research has demonstrated that prenatal care is strongly and clearly associated with improved pregnancy outcomes and prenatal care is especially important for women at increased medical and/or social risk. In developing countries, prenatal care services are scarce and minimal. Existing services provide mainly educational and screening functions unless high risk status is identified.

Study results showed that women who initiated prenatal care early in pregnancy were more likely to seek advice from a physician, were more knowledgeable about self-care and risks, and were likely to make more prenatal clinic visits. Women had inadequate knowledge about their optimum weight gain during pregnancy and cited anemia as a common problem, as did their physicians in the Tijuana area. They also reported that their male partners were not supportive about weight gain and other self-care behaviors.

The most desired source of pregnancy-related information was one-on-one or small group contact with doctors or nurses in clinic settings. Television, radio, pamphlets, and communicating with relatives were also important information sources. Using focus groups, informational and motivational materials were developed and then tested. The project produced prototypes for four communication

methods: A consciousness raising poster, a calendar with basic prenatal care messages, a pamphlet with expanded messages, and two songs with messages about the baby's father's responsibilities and the mother's nutritional habits. In addition, we recommend radio programs using local physicians for questions and answers and clinic discussion sessions whenever possible.

I. OVERVIEW

A. BACKGROUND

It is clear from the literature that prenatal care is correlated with improved outcome, both for the U.S. (Cortes 1985, Norris and Williams 1984, Bragonier, Cushner and Hobel 1985, Fuchs and Stubblefield 1984, Institute of Medicine 1985) and for developing countries (Ebrahim 1982, Faundes et al. 1982, Donaldson and Billy 1984, Lechtig et al. 1975, Lechtig et al. 1982). It is not clear why these visit should matter, nor how many visits provide the critical threshold to make the difference.

Prenatal care appears to provide risk assessment (identification of major problems of pregnancy as well as monitoring of fetal growth and maternal weight gain), prevention and treatment of infection, and acquisition of information and motivation leading to healthy behaviors, particularly in areas such as nutrition and avoidance of alcohol, smoking and other harmful substances. One question raised in the planning of this research project is to what degree all these activities, particularly the latter, are really provided by underfunded, understaffed prenatal programs in much of the world. Are some activities such as self-care, nutrition, self-detection of potential high risk conditions,

and encouragement for prenatal check-up possible outside of the clinic setting?

Another question centers around the optimum number of prenatal visits. While the traditional U.S. model calls for a minimum of 8 visits for a normal pregnancy, the World Health Organization specifies a minimum of 5 and the reality for Tijuana, our study site was estimated to be even lower. Yet, Guilkey and colleagues found that as few as three prenatal visits had a significant positive relationship to birth outcome in the Philippines (in press, also, Wong et al 1987). Also, Faundes and colleagues found that women with less prenatal care than the WHO 5-visit minimum still had significantly better outcomes than women with no prenatal care at all or token care (1982:11).

The research evidence emphasizes that "neither high technology nor costly specialists are needed to reduce perinatal risk when the level of perinatal mortality is as high as is usually the case in developing countries." (Faundes el al 1982:11). It seems logical, given scarce health resources in many countries, to maximize the timing and quality of the relatively small number of prenatal visits which is realistic for most women, and to supplement these visits with consciousness-raising and health educational programs.

As these questions surfaced, they were discussed with Drs. Rosa Luna and Hector Rivera of the Medical School of the Universidad Autonoma de Baja California (UABC) in Tijuana, Mexico. A solid working relationship of several years between UCLA and the UABC had produced several joint pilot research projects and an enthusiasm for continued collaboration. In particular, the UABC Medical School was implementing training in Public Health and

sought collaboration and support from the UCLA School of Public Health. In addition, prenatal and maternal health are considered a priority for the UABC. The Public Health services in Tijuana have a similar emphasis and the cooperation of their staff provided an added incentive to carry out this project.

B. SPECIFIC OBJECTIVES

The principal objective of this project was to produce educational materials which would increase women's awareness of the reasons for prenatal care, when to seek it, how to identify problems (high risk conditions) during pregnancy, and how to maximize self-care during pregnancy. Self-care was defined as nutritional behavior, stress reduction, and problem identification.

The precise forms of educational materials (posters, pamphlets, radio programs, etc.) were to be determined by the women of Tijuana themselves, and by the feasibility and potential for sustainability of the various options. In order to identify and develop these materials, three project phases were planned:

1. Phase I, Ethnographic: This phase consisted of anthropological fieldwork focusing in depth on a relatively small number of women to document attitudes, beliefs and behaviors related to pregnancy, to identify sources of health information, and to generate specific questions for the survey phase.

2. Phase II, Survey: This phase involved a community based sample of pregnant women to ask questions identified during the ethnographic phase which would need to be quantified.

3. Phase III, Design and Assessment of Educational Materials: This phase combined the findings from I and II and

brought them to bear on the design of educational materials. Design ideas and early versions of the materials themselves were tested with focus groups of women in Tijuana. Final materials were prepared for printing and other relevant forms of reproduction.

The specific objectives did not include the obvious fourth phase due to time and money constraints imposed by the original Request for Proposals. Instead, the utilization and long term appraisal of the materials will be carried out with other funding, probably under several different projects.

C. RESEARCH QUESTIONS

This project did not propose a specific hypothesis to be tested. Instead, it aimed to develop descriptive information on pregnancy which would be used to generate educational material for women and their families. Specific information was sought on:

a. The women's use of formal and non-formal sources of prenatal care

b. The frequency of prenatal care visits

c. The recognition of potential high risk conditions

d. Nutrition behaviors during pregnancy

e. The use of iron and vitamin supplements during pregnancy

f. Preferred and actual sources of prenatal health information

g. Stresses associated with pregnancy

h. Self care behaviors during pregnancy

Based on the answers to these questions, educational materials were generated and a new set of questions regarding their acceptability and utility were addressed using focus groups.

II. RESEARCH METHODOLOGY

An interdisciplinary team of anthropologists, media specialists, ethnographers, interviewers, economists, psychologists and public health specialists from UCLA and UABC participated throughout the project (see Appendix A). This section discusses the methodology for the two Ethnographic and Survey research phases. The third phase, Design and Assessment of Educational Materials, is discussed in section IV of this report.

A. PURPOSE OF THE ETHNOGRAPHIC AND SURVEY PHASES

1. Ethnographic Phase

The initial phase of the project was designed to document knowledge, attitudes, and practices regarding prenatal health care for currently pregnant women to obtain in-depth information using a variety of data collection techniques, and to provide question areas and draft wording for the survey phase. The combination of various techniques (informal interview, conversation, observation, participant observation) provides for more accurate findings through the triangulation of information. The same results are verified in various ways (see Scrimshaw 1989 for a detailed discussion of the mix of quantitative and qualitative methodology).

2. Survey Phase

The purpose of the survey phase was to conduct a baseline community household survey of currently pregnant women to assess

use of both formal and nonformal health services, knowledge of pregnancy risk factors, nutritional data and communication patterns.

B. SAMPLE SELECTION

1. Criteria

Selection of communities was based on a consultation with a demographer from the UABC. The geography of Tijuana was not conducive to random selection given our criteria of low socio-economic status. Instead, low SES communities were identified and then communities were selected to provide maximum geographic variability.

The criteria used for selection of communities for both research phases of the study were that the communities:

a. be within the political Jurisdiction of Tijuana,

b. represent both urban and rural communities,

c. be of low socio-economic status.

2. Communities

Based on these criteria, the following communities were selected. Two of the communities studied ethnographically had clinics offering prenatal care and two did not (La Obrera and Lomas Taurinas).

a. Rural Communities: El Florido, Flores Magón (ethnography and survey), La Gloria, El Tecolete, Canon del Sainz (ethnography only).

b. Urban Communities: El Rubi, Cerro Colorado, Lazaro Cardenas, Lomas Taurinas (ethnography and survey), El Rio, La Obrera (ethnography only).

3. Women

The criteria for sample selection were: currently pregnant women, low socio-economic status, living in Tijuana, ages 15-40. All women were interviewed in their homes by Spanish speaking interviewers.

During the ethnographic phase, permission was obtained from community leaders and health officials to enter the community. The researcher was introduced to key community leaders by health officials in most cases. The researcher then located 10 pregnant women in each community who were willing to participate in the research and who met the study criteria. In addition to the study criteria, the researcher tried to assure the inclusion of respondents who differed in terms of parity, months pregnant, age and years residing in Tijuana. The ethnographic data was collected primarily during February, March and April of 1988.

During the survey phase, an interviewer was assigned to go to the identified communities for the identification of survey respondents.

The initial steps in entering the community entailed a "visual census" of how many pregnant women resided in that community as well as a household census to determine if there were pregnant women in the household. All households were approached within each sample community. Initially we proposed a total of 400 interviews, however, during the survey phase a total of 451 were collected.

The survey data was collected during July and part of August of 1988.

4. Sample Size

The number of interviews by phase and rural/urban site is listed below:

Table 1

NUMBER OF WOMEN AND
COMMUNITIES PARTICIPATING IN STUDY

	Urban	Rural	Total
Ethnography			
Number of interviews	20	20	40
Number of Communities	2	2	4
Survey			
Number of interviews	285	166	451
Number of communities	5	4	9

5. Human Subjects Protection:

Each participant was given a written consent form (see appendices C and D) in which the purpose of the project was set out. It was explained that participation was voluntary, that results would be presented only in summary form, that individuals would not be identified in connection with information about themselves, and that they could cease to participate at any time if they so desired.

C. INSTRUMENT DEVELOPMENT AND DATA COLLECTION

1. Ethnographic Phase

The anthropological instruments consisted of data collection guides, or checklists, based on the field manual Rapid Assessment Procedures for Nutrition and Primary Health Care: Anthropological Approaches to Improving Program Effectiveness or "RAP" (Scrimshaw and Hurtado, 1987). Modifications to RAP guidelines were made for the current project and draft instruments were prepared. These ethnographic instruments were then tested with representative respondents, and were revised and refined with the assistance of several additional staff members from both UCLA and UABC. As agreed with the ICRW when this project was funded, these instruments were refined again after the ethnographic work and were published as an Appendix to the Spanish version of the RAP manual. Appendix D contains a copy of these instruments.

Two UABC ethnographers and two UCLA public health research assistants were trained to conduct the field work. The team members used laptop computers for entering the field notes. Some additional notes were handwritten and transcribed by the Tijuana based project secretary. The two UCLA researchers lived in their respective research communities for up to two months. The UABC researchers commuted to the communities from their homes in Tijuana.

The time originally planned for case studies proved to be insufficient for in-depth ethnographic work in the context of Tijuana. Thus, we decided to reduce the number of case studies from 15 to 10 cases per community. This allowed timely completion of the ethnographic phase while preserving the reliability of the

data base. We felt that quality of data was more important than quantity since the subsequent phases of the study would focus on quantitative questions.

2. Survey Phase

After analysis of the ethnographic data, quantitative data required for this project fell into four major areas:

a. Socio-demographic characteristics

b. Patterns of prenatal health care

c. Behaviors and perceptions during pregnancy

d. Sources of health information

Draft instruments were prepared based on data from the ethnographic phase and on instruments used by members of the research team for previous studies. Interview supervisors from Tijuana were trained and pilot tested the instrument with representative respondents. Drafts were then reviewed for clarity, as well as for the completeness of each question to assure that the instrument was culturally and linguistically appropriate to the study population. The final survey instrument appears in Appendix D.

With the assistance of the UABC Medical School, eight medical students were selected to participate in the survey as interviewers. Two supervisors from UABC and UCLA were selected to assist in the survey. A six-day training course provided interviewers with a clear understanding of interview techniques, methodology to be employed, and how to collect information from respondents by using precoded questionnaires. Data collection was carried out by interviewers during a five-week period. Research

team members coordinated the work and supervised interviewer training and data collection.

All questionnaires were administered by the trained interviewers. The responses from each participant were recorded on the questionnaire forms, and reviewed and cleaned at the end of each day by the supervisors.

D. DATA ANALYSIS

1. Ethnographic Phase

The ethnographic data was reviewed and analytic categories created based on the content of the information and on the data collection guide topics. The text was all entered into a computer using wordperfect, either in the field as data were collected, or shortly after data collection by the UABC project secretary. Ethnograph (software package) was used to label and then sort the ethnographic data.

2. Survey Phase

An interactive data entry and management system was used (Survey Mate) to enter all survey data. Coding specifications were developed by a statistician from UCLA. Two UCLA Public Health Students (Research Assistants) completed data entry of the 451 interviews. Data cleaning involved the usual checks for consistency, out of range variables, and missing information.

Data analysis was conducted using SPSS and consisted, for the most part, of simple frequencies and cross-tabulations, since the data was designed to be primarily descriptive. A few anovas and intercorrelation matrices were conducted as appropriate.

E. PROBLEM AREAS

Transportation to the field sites was the primary difficulty for both phases. We learned first-hand the access problems which could inhibit the use of health programs as researchers struggled up and down hillsides and experienced lengthy waits for buses. Only one interviewer was unable to complete the survey interviews as expected, but this did not affect the process or the total sample.

An additional difficulty was presented by the need to run the project through two Universities, in two countries, even though only three hours driving time separated us. There were additional costs in terms of telephones, communication and travel time, and coordination. The benefits were a combination of professional strengths at the two Universities which was instructive for all of us, an excellent field site for the project, and the opportunity to work in an environment where the results could be quickly applied. In our opinion, these advantages outweighed the disadvantages of conducting a joint project.

III. RESEARCH RESULTS

The information discussed in this section is a combination of data from the ethnography and survey phases. As a rule, the survey results are presented first and the ethnographic findings are then used to illustrate, explain and reinforce the survey results.

A. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Table 2 shows the sociodemographic characteristics of the respondents. As can be seen, the project goals of interviewing women with a range of ages, levels of education, timing of initiation of prenatal care, and the number of months pregnant at interview were achieved. The distribution of the number of months pregnant at interview was very even. For each month of pregnancy from three to nine months we interviewed between 10 and 15 percent of the sample.. Twenty-six percent of the women interviewed were experiencing their first pregnancy. Twenty-four percent of the women were age 19 or under, including nine women (2%) who were 15 or under. Only nine women (2%) were 40 or over.

Table 2

THE SOCIO-DEMOGRAPHIC

CHARACTERISTICS OF THE STUDY POPULATION

Characteristics	Mean	Range	
Age	24.50	13-47	n=443
Years living in Tijuana	13.05	0-39	n=444
Years of education	6.63	0-17	n=444
Month of pregnancy	5.0	1-9	n=444
Month care began	2.18	1-9	n=299
No formal care	0	0	n=143
Pregnancies	3.12	1-16	n=444
Live births	1.95	0-14	n=444
Living children	1.85	0-12	n=444

Marital Status	Percent	
Married	64.10	n=443
Consensual Union	31.60	n=443
Not living with baby's father	7.20	n=442

Work Status		n=353
Full-time outside home	9.10	
Part-time outside home	3.10	
Work for income at home	3.40	
Unemployed	76.50	

An examination of relationships between age groups and some of the socio-demographic variables was conducted. Analyses were conducted using five year age groups and also using two groups, women age 19 and under and women age 20 and older. The five year groups yielded numbers two small for many of the analyses conducted, so the two groups, teens (age 19 and under) and women 20 and over were used for most analyses. This was done in response to a request from ICRW staff that we focus some of the analysis on the differences between teenagers and older women.

Examinations of relationships between age and parity revealed the expected finding that younger women were more likely to be primiparous (Chi square = 127.73, DF = 1, $P < .001$), but 27% of the 106 women age 19 and under were multiparas, and most of these women had at least two living children at time of interview.

Age and education were correlated ($R = .2369$, DF = 441, $P < .001$), as might be expected, except that it was a negative correlation. An examination of cross-tabulations of age and education showed that while older *women* were more likely to have had no schooling at all, they were also more likely to have studied beyond the 6th grade, as well as beyond the 10th grade (Chi square = 25.18, DF = 5, $P < .001$).

Age was also related to whether or not women were living with the father of their baby. Eighty-seven percent of women ages 19 and under were living with the baby's father as compared to 94% of women ages 20 or older (Chi square = 4.6, DF = 1, $P < .05$). Similar differences also emerged when looking at whether women were married, divorced, or in a "free union" with the baby's father. Forty-three percent of the women ages 19 and under were formally

married, compared with 70% of the women ages 20 and over. Forty-seven percent of the younger women were in free unions, as compared with 27% of the women ages 20 and over. More of the younger women were divorced or separated (9%) as compared with the older women (3%) (Chi square = 25.9, DF = 2, P < .001).

When age was examined in relationship to whether or not a woman in either a rural or urban residence had worked during the past year, no significant differences were found.

B. UTILIZATION PATTERNS OF PRENATAL CARE SERVICES

1. Initiation of Care Patterns

Three initiation patterns were identified using three different items on the questionnaire to classify respondents as early initiators of prenatal care (Group 1), late initiators of prenatal care (Group 2) and non-initiators of prenatal care (Group 3). Prenatal care was defined as pregnancy related services sought from formal sources such as a private physician or a health center. Among the subjects, 65% were early initiators of prenatal care services, 21% were late initiators of prenatal care services, and 14% reported no prenatal care.

Table 3 shows frequencies for a number of socio-demographic characteristics for each initiation group. Chi square tests were used to examine differences between groups. There were no significant age differences by pattern of utilization. The average educational level was 6.6 years of education with early initiators of services being significantly more educated (F = 9.6, DF = 2, P <.001) than late or non-initiators. Early initiators had lived longer in Tijuana (mean 12.2 years) than non-initiators (mean 9.7

years). There were significant differences in marital status among the groups, with close to three quarters of early initiators married (Chi square = 27.6, DF = 6, P <.001) and 43.4% of non-initiators married. This is interesting in that significantly more of the younger women were not married, however there are no significant relationships between age and initiation pattern.

Those who sought formal prenatal care made from one to more than eight visits, although the mean number of visits was 3.4 and the median was 3.0. Analysis of variance for early and late initiators and number of visits showed significant differences between the two groups (DF=341, F=16.96, P < .001). The early initiators were likely to make more visits (mean = 4.9) than later initiators (mean = 3.1). Early initiation was also positively correlated with having experienced a prior pregnancy (R = .086, DF =442, P < .05) and with having lived in Tijuana longer (R = .1106, DF = 434, P < .01). Women who had lived in Tijuana longer also made more visits (R = .1309 DF = 434, P < =.01).

TABLE 3

SOCIO-DEMOGRAPHIC CHARACTERISTICS BY INITIATION PATTERN

	Total (N=444) Mean	Early (N=289) Mean	Late (N=93) Mean	Non (N=62) Mean
Age	24.6a	24.7	24.7	23.7
Number of living children	1.8a	1.7	2.1	2.2
Number of years living in Tijuana	11.7a	12.2	11.3	9.7*
Mean years of education	6.6a	7.1*	5.8	5.6
Number of persons in household	5.2a	5.1	5.2	5.6
	%	%	%	%
Marital status				
Married	64.1b	72.2*	52.7	43.5
Living together	31.6	25.0	39.8	50.0
Separated or divorced	4.1	2.4	7.5	6.5
Employment status				
Unemployed	76.5b	75.3	75.0	84.0*
Currently working	15.6	17.5	11.1	12.0
Other	7.8	6.9	12.5	4.0

a = one way analysis of variance
b = Chi square
*p < .001

Seventy-six and half percent of all respondents reported being unemployed, with late initiators more likely to be unemployed than the other two groups. Information on the number of living children shows that late and non-initiators were more likely to have two or more living children.

Table 4 presents data on the use of these services in ranked order for early and late initiators of care. Early initiators were

most likely to use a private physician and were significantly more likely to use private physicians than late initiators (Chi square = 63.1, DF = 2, P <.001). The second and third highest formal source of health care reported were the social security facilities and local health centers respectively. Late initiators reported higher use of these two government sponsored health services than early initiators. It is interesting to note that the ranked ordering of sources of formal care were similar for both groups which may reflect personal preferences or the perceived quality of care provided by these facilities. A one-way analysis of variance using a composite variable of use of all formal health care services revealed over all significant differences between the groups (F = 42.8, DF =2, P < .001). Post-hoc Newman Keuls procedure showed that early initiators have significantly different initiation patterns from the late initiator group (P < .05).

This findings are consistent with those obtained by Jasis (1988) in a survey of the border population conducted in Tijuana. The use of private medical services as well as early initiation of prenatal was found to be inversely correlated with income. Upper income women were more likely to choose the private sector and receive early prenatal care. Low income women were more likely to utilize public services (over 50%) although there was an overall preference for private care.

2. Use of Formal and Informal Prenatal Care Services

Among those respondents who do not initiate formal use of services, the major reasons given are lack of money and no insurance (15.4%). Approximately 27 percent reported that they

simply decided not to go, and one fifth (20.2%) of the non-initiators reported that they never go the first few months, do not like to go to the doctor, or did not feel it was necessary. Close to 13 percent of the non-initiator group did not initiate prenatal care because they were not sure if they were pregnant or had no physical symptoms. Surprisingly, only four respondents reported that the "medical facility is too far" while two respondents stated that they "didn't know where to go."

Table 4 also shows the use of informal health services by initiation pattern. Early initiators reported highest use of a "sobadora" (massage therapist) (6.2.%) and their own mother (5.2%). Among the late and non-initiator groups, close to 10% reported use of a "sobadora" and were less likely than early users to report reliance on their mother (4%). Among the non-initiator group, 3.2% reported using a midwife. The latter group was significantly more likely to utilize this source of health care Chi square = 2.9, DF = 2, P <.01). Close to 13% of the respondents in this group reported using "nobody" which was a significant variation from the other groups Chi square = 50.2, DF = 2, P < .001). This data suggests that pregnant women still rely to some extent on informal sources of health care.

TABLE 4

FREQUENCY OF USE OF FORMAL AND INFORMAL HEALTH CARE SERVICES BY EARLY, LATE, AND NON-INITIATOR GROUPS

	Total (N=444)	Early Initiators (N=289)	Late Initiators (N=93)	Non-Initiators (N=62)
Formal				
Private physician	45.5%	55.4%	45.2%*	--
Social Security	25.5	28.3	34.4**	--
Health Center	16.9	18.7	22.6**	--
General Hospital	4.7	4.8	7.5	--
Red Cross	2.9	2.1	7.5*	--
Informal				
Sobadora	7.2	6.2	9.7	8.1
Mother-In-Law	2.0	2.4	2.2	__
Mother	4.7	5.2	4.3	3.2
Pharmacy	3.6	1.6	1.1	.9
Midwife	1.1	.7	1.1	3.2*
Nobody	1.8	--	--	12.9

**$p < .00$ *$p < .01$

Categories are not mutually exclusive and sum to more than 100%.

4. Obstacles to Use of Services

Our ethnographic data provide more detail about low or non use of prenatal services. Women in that sample expressed concerns about walking up and down hillsides to reach main roads and transportation. Falling during pregnancy was greatly feared. From the researcher's experience, falling was a real risk in some of the hillside neighborhoods. In addition, some of the restrictions on the mobility of young wives observed by one of us in other Latin American countries (Scrimshaw 1973) continue to be in force in Tijuana. Some of the younger women studied did not go out alone because "it wouldn't look right" and their husbands wouldn't like it, so they were dependent on their husbands or female relatives to accompany them to prenatal care. A concept often stated during the ethnographic work was "Why should I go to a check-up if I feel well?" One woman noted, "It's a good idea to go to see a doctor during pregnancy so that one doesn't put the child's life in danger but I haven't gone during this pregnancy because I have felt well." Another said, "I should go to the doctor every month but when I feel something odd in my belly such as the child doesn't move or it becomes hard or I feel "boxed in" then I go to the "sobadora" or "one who massages".

A major theme which emerged during the ethnography was that of dissatisfaction with public health services (not explored in the survey due to space constraints and to that fact that it was so universal and obvious). Partly because of this, another important finding was the use of multiple services, a theme echoed by the survey data. In one case "Rosa" went to the local clinic for a check-up on Monday, as scheduled, but was told to return the

following day as the Doctors were not there (she was not told why). For the next three days the same thing happened. Finally, she went to another public clinic considerably further from her hous which costs her a day's wage and three hours of travel. The doctor there did not tell her how the baby was and "didn't even prescribe some vitamin pills". She now refuses to return to any public clinic and is hoping her husband can qualify for Social Security benefits so she can go to that hospital.

5. Content of First Prenatal Visit

When women are asked about initiating prenatal care they may be responding in terms of a simple check to see whether or not they were pregnant or they may have had a more thorough prenatal exam. In order to get a better sense of what happened during the first visit of the current pregnancy, the women were asked a series of "Yes/No" questions about exams and procedures. Their answers are summarized in Table 5.

TABLE 5

CONTENT OF FIRST PRENATAL VISIT

	Percent		
	Yes	No	
Performed a pregnancy test	72	28	n=318
Took blood pressure	75	25	n=321
Advised you to avoid alcoholic beverages	60	40	n=320
Advised you to eat certain foods during pregnancy	57	43	n=321
Recommended tetanus vaccination	33	67	n=321
Gave you vitamins	72	28	n=320
Advised you not to smoke	57	43	n=320
Took blood sample	64	36	n=321
Advised you which medications not to take	51	49	n=320
Advised you which foods to avoid during pregnancy	46	54	n=320

It must be remembered that the information in Table 5 is based on the woman's recollection of what took place, in answer to some very specific questions. Nevertheless, for purposes of improving pregnancy outcome, it is important to know what women remember. Based on Table 5, high proportions of the women were given advice about avoiding smoking and drinking alcoholic beverages, and were given vitamins. It is disappointing that only a third of the women recall having a tetanus injection suggested to them. We do not know if in fact it was only mentioned a third of the time or if

women do not recall it. Advice on diet was mentioned by the women around half the time. It is likely that these answers represent most, but not all, of the content of the prenatal care about which they were asked. It is clear that much of the time the first visit is much more than a token visit only to confirm the pregnancy, but includes examinations and medical advice.

6. Use of Pregnancy-Related Sources of Information

Table 6 shows that the most likely source of information for all respondents is the private physician. Female relatives, (mother and mother-in-law), and female friends are the second and third most frequently mentioned sources of information regarding prenatal care. Among the late and non-initiator groups, approximately one-tenth mention husband as a source of prenatal care information. Other sources of information include: sobadora, someone older, pharmacist, and midwife. Early initiators are more likely than the other two groups to use a mix of other sources for pregnancy-related information.

Ethnographic findings placed more emphasis on the woman's mother as a source of advice. For more educated women, the doctor was seen as coming first in authority, but the mother would be consulted first. This does not imply a contradiction between ethnographic and survey findings, but more likely represents a subtle depth on when, how and for what people are consulted. Our survey question was probably interpreted as referring to a more clinical type of information.

TABLE 6

RANKED ORDER FREQUENCY DISTRIBUTION OF USE
OF INFORMATION SOURCES
BY EARLY, LATE AND NON-INITIATORS

Sources	Total (N=444)	Early Initiators (N=289)	Late Initiators (N=93)	Non-Initiators (N=62)
Physician	50.5	60.2*	30.1	35.5
Mother	20.0	19.7	21.5	19.4
Nobody	13.1	8.7*	21.5	21.3
Husband	7.7	6.2	9.7	11.3
Mother-in-law	7.7	8.7	5.4	6.5
Girlfriend	5.9	5.9	5.4	6.5
Other	4.5	5.4	3.3	1.6

* $p < .001$

Chi square analysis reveals significant differences between the early initiator groups and the other two groups. The early initiators are more likely than the other two groups to obtain information on prenatal care from the private physician (Chi square = 31.95, DF = 2, $P < .001$). Early initiators are significantly less likely to report "nobody" as a source of information, while late and non-initiators are three times more likely to mention nobody (Chi square = 14.4, DF = 2, $P < .001$).

7. Perceptions of Prenatal Care

Among the early initiators of prenatal care services, the average month of pregnancy for initiating prenatal care is 2.8 months. Over 50 percent of the early and late initiators perceive the first trimester to be the most important time for taking precautions. Only 37.7 percent of the non-initiators perceive that a pregnant woman should take precautions in the first three months of pregnancy. Additionally, close to one-third of this group perceive the third trimester as the months one must take the greatest precautions.

The item asking why a woman should see a doctor when she is pregnant reveals that 42.8 percent report "to check to see how the pregnancy is progressing." Approximately 40 percent of all respondents report the major reason is "to see how the baby is doing." Other reasons given by the respondents include, "to avoid complications," "to obtain vitamins," and "to have a good delivery." Overall, eighty-three percent of the respondents reported that the reason to see a doctor is to monitor the health of the mother and baby. The only significant difference among the groups regarding this issue is that 15 percent of the non-initiators indicate the reason "to see if I need vitamins" influences their decision to seek care (Chi square = 9.6, DF = 2, $P < .01$), while only four percent of the early initiators reported the need for vitamins as a reason to seek prenatal care.

C. PREGNANCY RELATED BELIEFS AND BEHAVIORS

1. Stages of Pregnancy

As discussed under methodology, one of the reasons for this multistage approach was to increase the validity, or accuracy of the findings, as well as the reliability, or replicability. Thus, during the ethnographic phase we did not discuss pregnancy in terms of "trimesters", as health care providers and most health education literature use this term. Instead, we tried to elicit women's views of pregnancy through open-ended discussions. None of the women studied ethnographically described pregnancy in terms of stages or trimesters. "...it grows little by little. It seems to me to be more like a process." Women do, however, divide pregnancy into months, usually two through seven. There is also the concept of the early part or "the beginnings" of pregnancy and "el último", or the last month or two. A less clearly delineated middle section is described as "los mediados".

2. Concepts of Risk

One of the purposes of this project was to help women obtain information on how identify and respond appropriately to high risk conditions. The ethnographic data showed that the term "risk" (riesgo in Spanish), while a direct translation from the English, was not understood or much used by the women. When asked what "risk" meant to them in relation to pregnancy, most said: "The fear of childbirth, the birth itself". Upon discussion, the word "peligro" or danger emerged as most closely representing the concept of risk for these women. Danger implied the hazards of pregnancy, the things which could go wrong and hurt the baby.

Because of this, we used the word "peligro" in the survey instrument and again in the messages we designed for the communication phase.

The association between risk and phases of pregnancy varied in the ethnographic sample. Some women saw the early period as more dangerous because a woman may not realize she is pregnant and may not eat well or may take dangerous medications. Others saw this period as dangerous because the fetus is little and could easily be dislodged by a fall or other abrupt movement. Women also worried that a coraje or anger during this period could lead to abortion.

Most of the women studied ethnographically did not see the middle period of pregnancy as dangerous. The final months were seen as dangerous because of the size of the fetus ("it moves around a lot and can hurt you") and because of fear of the delivery itself. One woman echoed the feelings of many when she said: "Pregnancy is nothing unless the birth is bad. That is what gives me the most fear, actually it gives me goose-bumps. You never know what might happen."

Survey questions regarding risk focused around specific problems and symptoms. The data on perceived times of danger have already been discussed in relation to use of services. Questions on perceptions of baby movement showed that 41% of the women would fear that the baby was dead if they had been feeling regular movements and then they stopped. Nine percent of the respondents reported that "the baby was sick" if movement stopped, while 19% reported it was sleeping. When women were asked what they would suggest to a pregnant friend who had been feeling the baby move and

then felt no movement for several days, 93% would suggest that she see a doctor.

During the ethnographic work, the theme of danger from eclipses emerged. Concerns centered around the idea that eclipses can cause deformities or birth defects. People listened to the radio or watched television to find out when eclipses would occur. Women would try to stay indoors during an eclipse. A safety pin on the woman's underwear was also thought to protect against eclipse.

Ideal care during pregnancy was summarized by women in the ethnographic sample as meaning mild exercise, sort movements, rest, taking vitamins and eating well. Most women felt that they should not lift heavy objects as this could leading to bleeding and miscarriage.

(This section is incomplete and will contain more detail on specific perceived risks and problems). Close to one third of the ethnographic sample reported experiencing bleeding during pregnancy, although only one actually miscarried. All reported seeking care for the bleeding in the formal system. Reasons given for the bleeding included a susto (fright) anger (coraje), a fall and lifting heavy things.

One woman in the ethnographic sample began bleeding in her sixth month of pregnancy. She worried but did not seek attention until the flow increased. Her husband then became concerned and consulted his mother who examined the woman. The mother-in-law wanted her to see a doctor but the woman did not want to be seen bleeding on the bus. The local midwife was summoned. She examined the woman and tied a sheet around her to absorb the blood, then

convinced her to seek medical attention. The woman refused to go to a public clinic because of her mistrust of public facilities, so a neighbor drove her to a private clinic. Rest and an injection stopped the bleeding and contractions.

3. Weight and Weight Gain

The women surveyed were asked if they had ever had a "small baby" ("a baby who was born weighing too little"). Twenty one percent of the respondents said "yes". (note-figure is higher since 26% are primips-need to look up) When asked why babies are born weighing too little, 87% of the women said poor nutrition (por falta de alimentación), while another six percent said lack of vitamins. These responses indicate that women are well aware of the relationship between diet in pregnancy and the baby's weight.

Women were asked how much they thought the baby should weigh. Responses ranged from one kilogram to six kilograms, but the mean was 3.16 kilograms and the median was three. Women's responses were scored as correct or incorrect (too heavy or too light) and the resulting scored were cross-tabulated with prenatal care initiation patterns but no significant differences merged. Essentially, most women (84 percent) had correct impressions of ideal baby's weight.

Women's perceptions of their own weight gain were more complicated. Responses to a question about total weight gain in pregnancy ranged from 1 kilograms to 30. In addition, a third of the women sampled said they did not know the answer. The median response was seven kilos, but this does not take into account the number of women who said "0". (Note-we need to go back into the

data here). Women's responses were grouped into three categories, "low", "adequate" and "high". Fifty three percent of those who responded to this question were in the low group, 35 percent had a correct response, and 12 percent overestimated pregnancy weight gain. When these findings were cross-tabulated with initiation of prenatal care patterns, the differences were statistically significant (Chi square = 10.31, DF = 1, $P < .05$). Late and non-users of prenatal care were more likely to be in the "low" weight gain group (64.7% and 66.7%) as compared to early care initiators (48.8%). Of the three groups, early initiators were most likely to be in the adequate, or accurate weight gain estimate group (40.3% as compared to 25.5% for the late initiators and 14.8% for the non-initiators. It is not clear whether early use of prenatal care services increases women's knowledge or whether more knowledgeable women are more likely to seek earlier prenatal care. In all likelihood, there is an interactive pattern.

4. Anemia

The use of iron capsules was examined in relation to prenatal care initiation patterns. Early initiators were significantly more likely to be taking iron (62.9%) than late (50.6%) or non-users (13%) (Chi square = 50.85, DF = 2, $P < .001$).

(add ethnographic detail here)

5. Food and Food Habits

During the ethnographic phase, women identified relatively few food restrictions. Most of these were confined to foods considered bitter or acidic, such as lemons and chiles. These foods are

classified as "cold", and other cold foods such as ice and ice cream are also avoided because they might cause colics (stomach pains). It was thought this would make the fetus uncomfortable and make it turn around and upset the stomach. Acid foods are also seen as possibly causing chincual, or a red rash on the fetus' buttocks.

Other dietary restrictions noted during the ethnographic phase include coffee (the caffeine is seen as bad), salt ("because it makes your feet swell"), too many white flour tortillas and pasta, lard, oil because "they make the mother and child too fat" and pork "because of the little animals it contains". These attitudes reflect a good awareness of some of the actual dietary hazards during pregnancy.

The survey contained a question on which foods are good for you during pregnancy. Up to twelve foods could be coded. The responses were used to generate a food knowledge score, which was based on a sum of "correct" answers. This showed generally good knowledge, reinforcing the ethnographic findings. The mean for the sample was mentioning four healthy foods, the range was zero to ten. The food knowledge score was positively correlated with education ($R = .143$, $DF = 442$, $P < .001$), length of residence in Tijuana ($R = .1520$, $DF = 434$, $P < .001$). Early initiators of prenatal services also had higher food knowledge scores than late initiators or non-users of prenatal care (Chi square = 13.3, $DF = 4$, $P < .01$).

"Pica" or eating dirt was reported by four respondents and is often perceived as being associated with anemia. Women were embarrassed about this behavior and usually hid it from family

members. Clay was the preferred substance, although "white" dirt was also mentioned as popular. Some women bought magnesium tablets from pharmacies for this purpose.

6. Stress, Rest and Activity

During the ethnographic phase, women talked about the dangers of corajes or strong emotional upsets. Corajitos or little upsets, like reprimanding a child, are not dangerous, but with corajes one's face gets hot and one gets upset.

(to be expanded)

D. COMMUNICATION PATTERNS

Survey results showed the most frequent sources of health information can be classified into the general categories of: mass media, interpersonal communication with laypersons, and interpersonal communication with health professionals.

As shown in Table 7, the doctor was the single most important source of health information (84%), the second most frequent source was television (52%), and the third most frequent source was relatives, mostly the mother. Table 7 also shows that mass media was a powerful source of health information, and that printed materials in the form of health pamphlets and magazines were also frequently read by women for health information. Other studies have shown that Hispanic women have read pamphlets with health information, particularly those obtained from health sites (Alcalay et. al., 1988)

TABLE 7

Sources of Health Information

	Parity %			Use of Health Services %		
	1st Pregnancy	More than 1st Pregnancy			Early	Late
None Overall %						
Mass Media						
Television	53	51	56	44	44	52
Radio	23	36	35	28	27	32
Newspaper	9	13	14	10	7	12
Weekly Paper	2	7	6	4	5	5
Pamphlets	47	48	55	41	26	48
Picture Books	22	21	21	19	27	21
Magazines	45	41	45	40	29	42
Interpersonal Communication: Laypersons						
Relatives						
Neighbors	46	37	41	36	37	39
Friends	53	48	53	42	42	49
Interpersonal Communication: Health Professionals						
Midwife	6	10	7	9	16	9
Doctor	75	88	89	71	71	84
Social Worker	14	18	17	19	13	17
Nurse	21	33	33	27	23	30
Pharmacist	9	12	11	14	8	12

On the other hand, newspapers were not an appropriate medium to reach this population. These results are consistent with other studies (Alcalay et.al. 1988, Greenberg) that have found similar patterns of media use among low-income Hispanics in the U.S.

Communication with lay people can be an important source of health information for this population particularly with relatives or friends. On the other hand, the only health experts that were significant sources of health information were doctors and to a more limited degree, nurses.

Primiparous women utilized interpersonal communication with lay persons more than women who had been pregnant before. They communicated with health experts less frequently and used mass media almost equally with women who had been pregnant before. Women who started using prenatal care services early in their pregnancy used more categories of health information (except for midwife, social worker and pharmacist) than late users of care and even more so than non-users.

Table 8 provides a breakdown of the types of broadcast media, print media and group participation used as communication sources in this population. The high proportion of women who reported listening to music programs on the radio is of particular interest.

TABLE 8

GENERAL COMMUNICATION PATTERNS

TV Programs Women Watch	Percent
News	72
Soap Operas	76
Films	70
Female Program	33
Musical	42
Children	45
Talk Shows	43
Health	45
Community Service	33
Radio Programs Women Listen To	
News	59
Music	80
Talk Shows	36
Community Service	26
Soap Operas	13
Religious	9
Health	34
Print Media Use	
Story Books	23
Magazines	33
Newspapers	35

(Table 8, continued)

Group Participation (Weekly or Monthly)	
Church	43
Neighborhood group	16
PTA	12
Union	2

IV COMMUNICATION PHASE

The purpose of this phase was to apply the results of both ethnographic and survey phases to the development of a health education campaign using mass media and other appropriate means to meet the identified needs of the target population.

A. METHODOLOGY

The development of the health education campaign involved two steps:

1. Assessment of the ethnographic and survey results in order to identify areas of intervention in pregnancy-related behaviors and communication patterns of the target population.

2. Design of a health education campaign based on the results of study. This step included the following stages:

- -Design of health education materials
- -Pretesting of format and content of these materials in focus groups
- -Production of sample materials and further focus group testing

-Production of final materials in format for mass reproduction

Focus groups were conducted to document the responses to three components of the printed health education materials program, a poster, a calendar, and an informational brochure. There were two basic types of focus groups, one to guide the format decisions and the other to pretest proposed content of the materials. For the first type of focus group, women were shown two to four different graphic ideas. Their responses were documented, and subsequently this data was used to make the format decisions for each component of the campaign. Four focus groups of this type were conducted.

In the second type of focus group, women were asked to respond to proposed graphic ideas and written messages for a given component of the campaign. The responses from these groups were used to further refine the graphic elements and wording of messages. A total of nine focus groups of this type were conducted with the following breakdown:

3 for poster

4 for calendar

2 for pamphlet

All thirteen focus groups were conducted by a team of four trained field researchers. For every focus group, the research team prepared a guide which specified an objective in terms of the decision or action that would result from the focus group. The guides contained questions designed to evoke responses from the group which could be used to assess four different concepts:

Comprehension

Credibility

Cultural Acceptability and Relevance

Appeal

After each focus group field trip, the research team submitted a detailed observational report and a summary report of responses relevant to decisions or actions. This report was not only considered by all members of the research team, but also was reviewed in detail with the design consultant (Isaac Berdichevsky).

B. CAMPAIGN MESSAGES

The most significant areas pertaining to prenatal health care based on the survey and ethnographic data were:

1. Access To Care: Research results indicated that about a third of the women who were interviewed did not access formal health services for prenatal health care. Thus, one message needed to emphasize that women should have a prenatal examination <u>at least</u> three times during pregnancy: at the beginning of pregnancy, at the middle and towards the end. The importance of starting prenatal care early in the pregnancy was emphasized.
The need for some basic continuity of care was also stressed.

2. Nutrition: Our data indicated two major areas to be addressed:

Weight: Women lacked knowledge regarding the amount of weight they should gain during pregnancy, however their responses were more accurate regarding the amount the newborn was expected to weigh. Most women responded that if the newborn were to weigh three kilos, for example, they should gain about three kilos of weight during their pregnancy. A goal for the campaign was to

communicate the need to gain gradually between 10 and 12 kilos during pregnancy.

Anemia: Eighty two percent of the women associated anemia with poor nutrition. Results from the survey identified a positive awareness of the need for iron during pregnancy and iron deficiency in the form of anemia as a risk factor. In addition, women identified that they knew anemia during pregnancy was bad for the baby. In addition, clinicians in Tijuana have identified anemia as a problem for this population. Vitamins were identified as "goal for the body" and "giving strength." Because vitamins were found to be regarded with importance in this culture, especially during pregnancy, they can be regarded as a culturally acceptable vehicle for preventing anemia. A goal for the campaign included messages to prevent anemia through good nutrition and taking vitamins.

3. Risks During Pregnancy. The data showed that women needed more information on symptoms they can detect which could be early warning signs of risks to the pregnancy. Therefore the campaign included messages encouraging women to consult a physician if during pregnancy they noted any of the following list of symptoms:

Primary Messages (Calendar and Brochure):

Strong headaches

Swollen feet and hands (excessive swelling)

Cramping and it was too early to deliver

Vaginal bleeding

Secondary Messages (Brochure Only):

Fever or chills

Nausea

Rapid weight loss

Movements of the baby discontinued

Problems urinating

Excessive thirst

C. CHOICE OF MEDIA

Given the results from the survey and the ethnographic study, printed materials in the form of a poster, a calendar and a health pamphlet were selected for the campaign (see Appendix B for text and photographs of these materials). Each medium complements the other by providing a more in-depth level of information than the previous one.

The poster consists mostly of a visual message with minimal text to support the image; the purpose of the poster is to increase women's awareness of the seriousness of pregnancy, as well as the importance of being informed and taking good care of themselves. Posters were chosen as a visually attractive way of capturing women's attention onto the campaign's main goal. The poster portrays a young pregnant woman. The pregnancy is advanced far enough to be obvious, but is clearly in the second rather than third trimester. This deliberate difference in emphasis when compared to most other posters about pregnancy, was to show that attention should be given to the pregnancy early on. The text was very much the same text dictated by the women in the focus groups. To our surprise, they picked the words: "Pregnancy is a serious matter: Inform yourself, take care of yourself". The poster also contains a call to action: "Seek medical care (at the least) at the beginning, the middle and the end of pregnancy."

The calendar was designed to provide cues to action for the four main areas identified by the survey where key information was needed for this population: use of prenatal health care services at least three times during the pregnancy, weight, nutrition, and risk prevention. The calendar balances visual elements with text. Several images were tested for each topic. The ones finally selected reflect the choices of the women in the focus groups. A calendar was chosen so that women could hang them in their homes, and therefore be exposed to the messages frequently. The calendar's design allowed for a new block of months to be inserted per new year, so that it can be used year after year. The calendar should be distributed free of charge through a variety of community outlets, and promoted by the local media.

The health pamphlet was designed to provide a more detailed explanation on each one of the areas identified as important for the campaign. This survey, in addition to other studies, has shown that pamphlets are an effective way to reach Hispanic women regarding health information. The pamphlet's cover has the same picture as on the poster, and the text includes a series of simple questions and answers on the same issues as the calendar. Each answer provides in-depth information about the reasons the actions promoted are important for a positive pregnancy outcome. The intention is to make this brochure available through community organizations, private physicians, clinics, and local television and radio stations.

The last element for the campaign is a demonstration cassette of two songs (see Appendix B for texts), composed and produced in draft form. The survey data indicated that radio media has a high

potential to reach this audience with a mean listening time for this sample of seven hours. The songs were ideally suited to dramatizing two campaign messages, nutrition and paternal support.

Both ethnographic and focus group results supported the importance of radio indicated by the survey respondents. Here, several alternative formats are available: Brief advertisements (called cuñas), songs, "novels" (continuing stories) and advice or talk shows (with or without telephone call-in). Women were particularly attracted by the idea of songs, which is why we developed some. We felt that novels were beyond the scope of this project and would have limited use since they would not bear repetition. A format we strongly recommended, which could be developed locally in different regions, is an advice or talk show. Women repeatedly indicated they wanted one-on-one communication which is not feasible. An advice show, however, can feel quite intimate and "one-on-one". We suggest putting knowledgeable and articulate physicians together with local radio stations for brief advice or talk shows which could run weekly or more often for an indefinite period of time.

Although television was identified as an important source of health information for the target population, it was not used for the following reasons:

1. Fleeting nature of TV messages. Communication research has shown than TV is not effective in providing information or changing behaviors on complex matters that need to be communicated clearly and repetitively in order to be adopted. Because of these findings,

the multiple messages and behaviors promoted by the prenatal care campaign made TV a less appropriate choice than printed material.

2. Extremely high cost of TV production, which is beyond the project's budget.

Thus a poster, a calendar, a pamphlet and songs appeared to be a good compromise which combine attractive visual components with relevant text. These choices also offered some guarantee of permanence, particularly the calendar.

V. CONCLUSIONS AND RECOMMENDATIONS

A. NEED FOR INFORMATIONAL MATERIALS TO IMPROVE PREGNANCY OUTCOME

At the beginning of this project two of the investigators (Drs. Hector Rivera and Susan Scrimshaw) traveled to Mexico City to seek similar projects and educational materials to test or adapt for the Tijuana area. A number of projects for training health workers were identified, as were several primary health care and child survival projects. Nothing was found which focused specifically on pregnancy with the detail produced by this project.

There was also some question raised at the beginning of the study about the degree of need for the Tijuana area. Our research found that in fact, lack of, or inadequate transport is a serious constraint in the provision of health care in the city itself, and even more serious in the rural areas. Private sector and government facilities carried constraints in access to Health Care in terms of physical access (distance and travel time), eligibility, or qualifications required to receive care at a particular facility. Accessibility in terms of distance or travel

time and in terms of congestion or waiting time, varies greatly for residents of different parts of Tijuana.

More important, women varied greatly in their actual use of biomedical prenatal care, and in their perceptions of need for such care. Our ethnography, survey and focus groups revealed key areas of information which could be provided to women through a series of mutually reinforcing educational strategies.

B. THE NEXT STEP

This project went only as far as producing the camera ready materials, which had been evaluated during their development. Two private organizations in Tijuana (a pharmaceutical company and a drugstore chain) have agreed to fund the production of the calendar and the pamphlet. In addition, Ross Laboratories (in the U.S.) and Foster Parents Plan International have expressed interest in underwriting the production of these materials. Foster Parents Plan officials are interested in adapting the materials to local cultures in Guatemala and in Honduras through additional focus groups. Photographs would be redone to suit local populations.

The second obvious next step, beyond making the materials available to some programs, is to test them using an operations research design. This would involve the collection of baseline information in test and control communities, then disseminating the materials in the test communities for a time. Evaluation would consist of a repeat of baseline studies to measure knowledge, attitudes and behaviors, and possibly, some attempts to measure changes in outcome, although this would need such a large population that it might not be cost-effective. UCLA, through the

Western Consortium for Health, is part of the team involved in the recently awarded Mothercare Project. Discussions are currently underway with staff at John Snow Associates, the prime contractor, to consider a trial of the materials developed for this project under the auspices of the Mothercare Project.

C. DISSEMINATION OF RESEARCH FINDINGS

We have always felt that there are multiple audiences for this project. One is the readers of U.S. and international health journals. The second is the many health planners and health care providers at local levels, particularly in Mexico.

Drs. Luna and Rivera will focus on this second group, using their professional standing and networks. The UABC has a cooperative professional training agreement for its medical students with the Federal Secretariat for Health which provides for internships. This establishes a functional integration of professional medical and human services training in the service delivery centers. Thus, the UABC and the Mexican Government have combined forces and our project has the potential for impacting their joint efforts. A series of conference and workshop presentations and in-service training sessions is being planned.

Publications are planned for Mexican and well as U.S. and international outlets. The research team has planned a series of papers with various configurations of authors to follow this report. The first to be completed focuses on prenatal care utilization patterns, and will be submitted to Health and Social Behavior in October of 1989 (Zambrana, Scrimshaw, Estupiñan and Luna). The section of this report on utilization patterns draws

heavily on drafts for that paper and reflects particularly strong input from Ruth Zambrana. A second focuses on the use of mass media for information and on the design of the informational materials (Alcalay, Scrimshaw, Ghee, Estupiñan). The section of this report on the development of the educational materials draws heavily on drafts for that paper and reflects strong input from Rina Alcalay and Saskia Estupiñan. A third presents the core findings of the survey and ethnographic work (all investigators). Its working title is "Behavior During Pregnancy in Tijuana, Mexico". A fourth will focus on food related beliefs and behaviors in pregnancy, with particular emphasis on the ethnographic findings (Scrimshaw, Luna, Leslie and Schatz). Another will emphasize the detailed findings derived from the focus groups (Ghee, Durazo, Abernathy, Abundis, Luna). Another will focus on the policy implications of women's health information sources (Estupiñan et al). Another will analyze the pros and cons of the combination of methodologies used (Scrimshaw, Zambrana and ?). Drs. Luna and Rivera will develop one or more articles aimed at informing their medical colleagues regarding the pregnancy attitudes and behaviors of the women studied, as well as assessing the implications for their program planning and clinical work.

D. EVALUATION OF THE ICRW PROGRAM IN RELATION TO THIS PROJECT

The ICRW program under which this research was conducted provided a great deal more than funding. Intellectual support and stimulation were very important to the quality of the work possible under the contract as well as to our morale. The sense of interconnectedness to other projects was also extremely important.

The summaries of other projects provided both a context and a stimulus for our own.

We feel that we undertook an extremely ambitious project for the relatively short amount of time allocated. Any one of our three phases could have been done in the time frame of the entire project; instead, we did all three. If forced to chose fewer phases, we would do the ethnography, materials design and focus group and omit the survey. Nevertheless, we learned some things from the survey (such as the mistaken views of weight gain) which we did not learn in the ethnography. Much of the information generated in the ethnography guided the survey to such an extent that we could not imagine doing without this phase.

It was difficult, but well worth while, to work in two countries through two institutions. Ideally, we should have had more time to work through each phase in both institutions, to have fuller discussion with faculty and students to benefit both them and the project. We skipped many of the social niceties so important to international work and forged ahead to meet our goals and our timetables. It is a tribute to a remarkable team and to excellent support from the ICRW that we succeeded.

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APPENDICES

A. Project Personnel

B. Educational Materials

C. Ethnographic Instruments: Revised RAP Guides

D. Survey Instrument

APPENDIX A. PROJECT PERSONNEL

Prenatal Health Behaviors in Mexico
UCLA/UABC
September 15, 1989

APPENDIX A

PROJECT PERSONNEL

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Prenatal Health Behaviors in Mexico
UCLA/UABC
September 15, 1989

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APPENDIX B. EDUCATIONAL MATERIALS

Prenatal Health Behaviors in Mexico
UCLA/UABC
September 15, 1989

APPENDIX C. ETHNOGRAPHIC INSTRUMENTS: REVISED RAP GUIDES

Apéndice 2

Guías de Recolección de Datos: Ejemplo de Su Modificación para Otra Aplicación

Estudio sobre el Embarazo en Tijuana, B.C., México

Nota de los Editores

Este anexo es un ejemplo de la adaptación de la metodología del RAP para un proyecto específico. Consiste en guías producidas para un proyecto sobre el uso de medios masivos en una comunidad mexicana para mejorar el cuidado durante el embarazo. Para crear mensajes sobre el cuidado durante el embarazo, fue necesario hacer un estudio comunitario usando la metodología del RAP. Algunas guías se usaron sin cambiarlas, otras se reducieron y se combinaron, otras se ampliaron y, además, se crearon unas totalmente nuevas. Estas guías demuestran la flexibilidad en esta metodología, enseñando que se deben modificar las guías para cada situación y no utilizarlas tal como están en el RAP.

El equipo de trabajo para este proyecto consistió en: Rina Alcalay, Gabriela Escalante, Saskia Estupiñán, Martha Gonzales, Rosa Luna de Rivera, Salvador Meza, Diana K. Moody, Hector Rivera, Sara Schatz, Susan C. M. Scrimshaw y Ruth Zambrana.

60

Acuerdo de Participación en el Estudio

Buenos días, mi nombre es _____. Estoy, por parte de la Universidad UABC y con el permiso de la Secretaría de Salud, en esta comunidad para realizar un estudio sobre el cuidado del embarazo. Usaremos los resultados de este estudio para desarrollar materiales de información para mujeres embarazadas.

Le queremos pedir el favor de: hablar con usted sobre sus ideas de salud y del embarazo, y de fuentes de información. Queremos platicar un rato hoy y visitarla algunas veces más, pero queremos tener cuidado de no interrumpir su trabajo. Podemos terminar de platicar cuando usted lo desee. Si hay preguntas que no quiere contestar o que no entiende, dígame; está bien.

Si usted está de acuerdo en participar, le agradezco mucho su colaboración y le ruego que ponga sus iniciales en esta hoja, la cual le dejaré una copia. Su nombre no va a ser utilizado en ningún informe, pero sus ideas y sugerencias pueden ayudar en hacer materiales educativos para mujeres embarazadas. Si usted no desea participar en este estudio le agradezco por su tiempo.

Estoy de acuerdo a ser entrevistada

_____
(Iniciales o marque una X si desea)

Entrevistador

Nombre _____

Dirección _____

Fecha _____

Comunidad

C. 1 Características Geográficas[1]

Técnicas: Investigación bibliográfica, observación

Comunidad

Tipo de comunidad:

- Urbana
- Peri-urbana
- Semi-rural
- Rural
- Viviendas agregadas
- Viviendas dispersas

Localización y transporte:

- Accesibilidad por rutas terrestres
- Distancias a centros urbanos (kilómetros y tiempo)
- Carreteras, vehículos, disponibilidad de transporte, costo de transporte, barreras (horarios, espacio, de estación, etc.)

Topografía

Clima y estaciones

Mapa (si es posible): Area, límites, carreteras, características físicas

C = Comunidad; H = Hogar; P = Proveedores de Atención Primaria de Salud.

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62

C. 2 Características Demográficas y Epidemiológicas[1]

Técnicas: Investigación bibliográfica, entrevistas con informantes claves/autoridades, observación

Comunidad

Tamaño de la población (durante el período de estudio)

Estadísticas vitales

Grupos étnicos

Distribución por sexo (hombres/mujeres)

Distribución por edad (<1, 1-4, 5-9 años, etc. y/o porcentajes de menores de 5 años, de 15 años, y de mayores de 65)

Población económicamente activa (porcentaje por edad y sexo)

Patrones de migración (estacional para trabajar, rural-urbana, etc.)

Lenguas habladas y escritas

Grupos religiosos

[1] Si hay disponibles y si son importantes para los propósitos de la investigación.

C. 3 Características Socio-económicas

Técnicas: Investigación bibliográfica, entrevistas con informantes claves/autoridades, observación

Comunidad

Organización Comunal
- Carácter y fuerza
- Actitudes hacia servicios gubernamentales y costos
- Autoridades locales
- Líderes
- Grupos (clubes religiosos, ocupacionales, económicos [de ahorros])
- Saneamiento ambiental (desperdicios de basura, drenaje, excretas, productos de desecho industrial, quema de basura)
- Contaminación ambiental-industrial
- Disponibilidad de agua (red, discretas, llave, pipas, tambos, pilas y botes)

Organización Doméstica
- Familia nuclear vs. extendida[1]
- Patrones de residencia
- Tenencia de la tierra

Características Económicas
- Actividades económicas
  - Patrones
  - Principales actividades (hombres/mujeres)
  - Desempleo y sub-empleo (por edad y sexo, si posible)
- Ingreso por cabeza
- Distribución de la riqueza (proporciones)
- Tenencia de la tierra/acceso a la tierra (dueños de lote, rentando el terreno)

[1] Las definiciones aparecen en el Capítulo 1.

C. 4 Recursos de Salud[1]

Técnicas: Entrevistas con informantes claves/autoridades, observación

Comunidad (Puede haber información a nivel nacional, regional y local)

Recursos de salud utilizados por la comunidad (incluye aquéllos fuera de la comunidad que sean utilizados por miembros de la comunidad)

- Tradicionales[2]
- Modernos o biomédicos occidentales
  - Tipos de practicantes e instalaciones
- Transporte a los recursos de salud
  - Distancia al recurso
  - Tipo de transporte (a pie, autobús, etc.)
  - Costo
  - Tiempo que se lleva en llegar al recurso
  - Otros factores (caminos malos, transporte falla a veces, etc.)

[1] Guías más detalladas para obtener información sobre los recursos de salud aparecen más adelante.

[2] Los practicantes de salud pueden serlo a tiempo parcial o de vez en cuando.

C. 5 Comunidad: Fuentes de Información

Técnicas: Observación, datos públicos

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

¿Cuáles son las fuentes importantes de información en general?

Promotoras de comunidad

Vecinos/amigos

Familiares: ¿Quiénes?

¿Cúales son las vías de comunicación importantes en la comunidad?

- Televisión
- Radio
- Cinema/películas
- Revistas
- Fotonovelas
- Periódicos
- Folletos
- Afiches/pósteres
- Carteles
- Altoparlante/carro
- Pláticas

¿Quiénes son las personas o cuáles son los lugares donde (o através de) se consigue su información?

- Escuela/maestro
- Centro cívico
- Salón social
- Casa comunal
- Sacerdote/iglesia
- Alcalde/líder de comunidad (específique)
- Médico, enfermera, clínica
- Otros

Hogar

H.1 Historia del Embarazo

(Usar esta guía en conjunto con la guía H.8, i.e., durante la misma entrevista.)

Técnica: *Entrevista*

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

Registrar la siguiente información acerca del embarazo actual.

¿Cuándo supo que estaba embarazada?

¿Cómo supo que estaba embarazada?

¿Se está cuidando el embarazo? Si la respuesta es sí, preguntar ¿cuándo, cómo y dónde?

¿Quién le está atendiendo o revisando durante su embarazo? ¿Quién la cuida (médico, partera, madre, vecina, comadrona, sobadora etc.)? (Utilizar la guía H.2 para indicar el número de visitas.)

Si dice que nadie le está atendiendo, preguntar ¿qué hace al momento para cuidarse? ¿Cuáles son las razones para escoger esa asistencia?

61

.. 2 Utilización (para ella) de los Recursos de Salud Durante el Embarazo (Lista de Frecuencia)

Técnica: *Entrevista*

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

Recurso[1]	¿Alguna vez lo ha usado?[2]	¿Cuantas veces?	¿Para qué?
Pariente			
Vecino o amigo			
Curandero			
Espiritista			
Huesero			
Homeópata			
Herbario			
Enfermera			
Comadrona/partera			
/eccionista			
Farmacia/farmacéutico			
Tienda			
Mercado			
Promotor de salud			
Centro de salud			
Dispensario de salud			
Clínica móvil			

.os recursos disponibles variarán de una comunidad a otra.

[2] Incluye prevención y tratamiento de enfermedad.

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H. 3 Experiencia e Utilización de Recursos

Técnicas: Entrevista, conversación

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

¿Ha consultado con alguien durante su embarazo?
(Referir a los recursos mencionados en la guía H.2.)

¿A quién consultó?

¿Porqué fue a consulta?

¿Cuántos meses de embarazo tenía?

¿Qué paso?

¿Qué impresiones tiene/tuvo?

¿Qué beneficios obtuvo?

¿Si consultó en un servicio de salud, tuvo algún problema?

Preguntar sobre el tiempo, tratamiento, privacidad, confianza, distancia.

- ¿Cuánto tiempo duró la consulta?
- ¿Cuánto tiempo tardó en ida y vuelta?
- ¿Cuánto tiempo estuvo con la enfermera?
- ¿Cómo le trataron?
- ¿Sintió Ud. confianza con la persona que le atendió?
- ¿Le pareció que había bastante privacidad?
- ¿Regresaría Ud. a ese lugar o con esa persona? ¿Porqúe?
- Si no regresaría, ¿cómo podrían ellos mejorar el servicio?

¿Piensa que una mujer embarazada debe controlarse/visitar un médico, partera, etc. durante el embarazo? ¿Cada cuánto debe ir?

¿Porqué debe (o no debe) ir?

¿Piensa que le protege? ¿Contra qué problemas?

¿Ha recibido vacuna antitetánica? ¿Si no, porqué no ha recibido una?

H. 4 Comportamiento Ideal/Real Durante el Embarazo

Técnica: *Entrevista*

(Tener cuidado no sesgar.)

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

¿Qué piensa que una mujer puede hacer para tener un niño sano?

¿Hay ciertas cosas que una mujer embarazada debe o no debe hacer?

¿Debe hacer menos? ¿Debe hacer más? (Por ejemplo, en cuanto a trabajo, atender a la familia, a los niños, esposo, etc.; cargar y levantar cosas pesadas; subir/bajar de peso; dormir y descansar, etc. Usar dibujos.)

Preguntar sobre su actividad sexual

Si descansa (por algunas horas) o si duerme (más o menos 8 horas). ¿Ha oído Ud. hablar que se pega el niño adentro? ¿Porqué dicen que se pega el niño?

¿Qué considera la mujer como cuidado ideal durante el embarazo?

¿Lo hace?

Cuidado ideal	Cuidado real

¿Piensa que los otros miembros de la familia deben hacer cosas especiales para la embarazada?

H. 5 Crecimiento del Niño

Técnica: *Entrevista*

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

¿Cómo explica la gente por aquí el crecimiento del niño en la panza?

¿Cómo se va formando?

¿Cree Ud. que una niña y un niño se forman igual o diferente?

¿Porqué se formarían diferente?

(Tratar de explorar si ella distingue el tamano del producto y cómo lo distingue, si está grande o si está chiquito y cuándo está grande o chiquito.)

¿Cuándo empezó Ud. a sentir los movimientos del niño adentro?

¿Cuándo se debe sentir los movimientos fuertes?

¿Le preocupa si un niño deja de mover si ya ha sentido movimientos fuertes? ¿Porqué?

¿Se le ha encajado alguna vez el niño?

¿Le duele cuando se encaja el niño?

¿Qué hace Ud. cuando se encaja el niño?

¿Le ha puesto dura la panza durante su embarazo?

¿Porqué cree que se pone dura?

H. 6 Etapas y Riesgos

Técnicas: Entrevista, conversación

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

Pasos del embarazo. (Preguntar si ven etapas, meses, pero sin sesgar.)

¿En qué fecha espera el niño/a?

¿Hay meses más difíciles/peligrosos que otros? ¿Cómo se debe cuidar durante estos meses?

¿Hay meses durante el embarazo cuando hay que tener más cuidado? ¿Cuáles son?

¿Hay algo que le da miedo durante el embarazo? ¿Qué es? ¿Porqué?

¿Cómo piensa que se va a sentir cerca del tiempo del parto?

¿Cómo piensa que va a ser el parto?

¿Cree Ud. que el tamaño de la panza afecta la salud del niño? ¿Cómo? ¿Porqué?

Tratar de explorar como percibe ella una panza grande/una panza chiquita. (Crear dibujos que corresponden a los meses del embarazo.)

¿Diría que este embarazo ha sido normal/regular/difícil/algo pesado/muy pesado?

¿Cómo explicaría Ud. que ha sentido este embarazo? (Tratar de explicarle que quiere saber las palabras que ella utiliza.)

H. 7 El Cuidado de Embarazadas Enfermas

Técnica: *Entrevista*

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

Anotar las enfermedades o problemas padecidos por la embarazada del hogar durante este embarazo en forma de tabla como se muestra abajo.

Enfermedad	Causa percibida	Duración	Tratamiento	Costo

Ideas sobre la prevención de las enfermedades mencionadas:

Enfermedad	Posibles medidas preventivas

H. 8 Inventario de Síntomas

Técnica: Entrevista

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

Yo le voy a leer una lista de posibles quejas y quiero que Ud. me diga si Ud. ha sentido algunas de estos problemas absolutamente no, un poco, algo, mucho *durante los últimos 8 días.*

	Síntoma	Sí	Algunas veces	No
1.	Dolor de cabeza	1	2	3
2.	Dificultad en respirar	1	2	3
3.	Le sudan las manos	1	2	3
4.	Ha estado triste	1	2	3
5.	Agruras	1	2	3
6.	Se le acelera el corazón	1	2	3
7.	Mareada/mareos	1	2	3
8.	Pies, manos, cara hinchada	1	2	3
9.	Dolor de espalda/cintura	1	2	3
10.	Náusea/vómitos	1	2	3
11.	Nerviosa	1	2	3
12.	Manos o pies fríos	1	2	3
13.	Estreñida	1	2	3
14.	Desvelándose	1	2	3
15.	Varices	1	2	3
16.	Poco apetito	1	2	3
17.	Diarrea	1	2	3
18.	Le tiemblan las manos	1	2	3
19.	Cansada	1	2	3
20.	Lloró	1	2	3
21.	Asco	1	2	3
22.	Calenturas frecuentes	1	2	3
23.	Flujo/desecho	1	2	3
24.	Mucha sed	1	2	3
25.	Infección vaginal/molestias	1	2	3
26.	Se rompió la fuente/bolsa	1	2	3
27.	Sangrada vaginal	1	2	3
28.	Mal de orín	1	2	3
29.	Contracciones/dolores como si fuera a aliviarse	1	2	3
30.	Se le abre la cintura	1	2	3
31.	Tiene tos	1	2	3
32.	Mal de riñón	1	2	3

H. 9 Historia de Fecundidad

(Usar con la Tabla H.9)

Técnica: *Entrevista*

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

La tabla adjunta resume la siguiente información:

Número de embarazos
Número de hijos vivos
Número de hijos muertos
Número de abortos

Encuestador: marque los números del orden de los embarazos en la columna 1.

1. ¿Cómo se llama (el primer hijo que nació; el que sigue)?
2. ¿Es varón o mujer?
3. ¿Nació vivo? (Si dice que no, vaya a la pregunta 8.)
4. ¿En cuál mes y año nació este hijo?
5. ¿Todavía vive este hijo? (Si dice que no, siga con las preguntas.)
6. ¿En cuál mes y año se murió?
7. ¿En su opinión, porqué se murió?
8. ¿Cuántos meses de embarazo tuvo cuando nació este hijo?
9. ¿Quería Ud. tener este hijo?
   (Esta pregunta y las siguientes son para ver si le admite un aborto provocado.)
   (Si dice que no, siga con las preguntas.)
10. ¿Hizo Ud. algo para no tener este hijo? (Si dice que sí, vaya a la pregunta 11.)
11. ¿Qué hizo Ud. para no tener este hijo?

Tabla H. 9

Historia de Fecundidad

	1 Orden del embarazo	2 Nombre	3 Sexo	4 ¿Nació vivo? (Si no, vaya al #8)	5 Fecha de nacimiento	6 ¿Todavía vive? Sí	No	7 ¿Cuándo se murió? Mes	Año	8 ¿Porqué se murió?
1.										
2.										
3.										
4.										
5.										

	9 Meses cumplidos del embarazo cuando nació	10 ¿Quería Ud. tener este hijo? Sí	No	11 ¿Hizo algo para no tener este hijo? Sí	No	12 ¿Que hizo para no tener este hijo?
1						
2.						
3.						
4.						
5.						

H.10 El Tamaño Ideal de la Familia

Técnica: *Entrevista*

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

1. Cuándo supo que estaba embarazada, ¿cómo se sintió?
2. ¿Ahora se siente diferente? ¿Cómo?
3. ¿Quiere Ud. más hijos de los que tiene ahora?

   Sí No (Vaya a la pregunta 5.)

4. ¿Cuántos niños más quiere?
5. ¿Hubiera querido tener menos hijos de los que tiene ahora?

   Sí No

6. ¿Cuántos hijos cree Ud. que serían una buena familia en estos tiempos?

   ____ Número de hijos ____ Los que Dios dice ____ No sabe

7. ¿De los ____ hijos que Ud. piensa son una buena familia, cuántos quisiera que fueran varones y cuántas quisiera que fueran mujeres?

   ____ Número de varones

   ____ Número de mujeres

   ____ Da igual

8. ¿Cuántos hijos piensa Ud. que su marido desearía que Ud. tenga?

   ____ Número de hijos ____ Todos los que pueda ____ No sabe

9. ¿Cuántos hijos tuvo su mamá?

   ____ Número de hijos

11

H. 11 Métodos Anticonceptivos

(Usar con la Tabla H.11)

Técnica: Entrevista

¿Me podría decir cuáles son los métodos que Ud. ha oído hablar que se puede usar para no quedar embarazada? (Anote todos los métodos que menciona en la columna 1.)

¿Ha usado en el pasado algo para evitar los embarazos? ¿Qué? (columna 4)

Si menciona algo después, lea la lista estando segura que comprende cada método y anote si lo conoce en las columnas 2 y 3.)

¿Dónde se puede conseguir (dónde ha conseguido Ud.) estas cosas para no quedar embarazada? (Chequee todo lo que dice.)

Doctor
Botica
Comadrona
Maternidad
Clínica: ¿Qué clase?
_____ de planificación familiar
_____ de salud (del gobierno)
_____ médica (privada)

Otro: _____
No sabe

Tabla H. 11

Métodos Anticonceptivos

(Usar con la guía H.11)

Método	1 Mencionado antes de oír la lista	2 Conocido después de oír la lista	3 No conocido después de oír la lista	4 La ha usado alguna vez	5 Piensa utilizar en el futuro	6 Falla en alguno de los métodos
Pildora/pastilla						
DIU/aparato						
Preservativos condon						
Terminar afuera; el me cuida						
Ovulos vaginales						
Jalea o crema vaginal						
Lavado vaginal						
Espuma vaginal						
Ritmo						
Inyecciones						
Diafragma						
Operación de la mujer						
Operación del hombre						
Otro						
Ninguno						

H. 12 Comidas Que Comen las Mujeres Embarazadas

Técnicas: Entrevista, observación

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

¿Me podría decir lo que comió Ud. ayer en todo un día?
(Si no se acuerda, preguntar lo que normalmente come en un día; anotar en forma de tabla lo que dice.)

Mañana (Desayuno)	A medio día/Por la tarde (Comida)	Por la noche (Cena)

¿Cuáles son las comidas que Ud. come solamente de vez en cuando? Hacer una lista de las comidas que come de vez en cuando y volver a preguntarle que tan frecuentemente se las come anotándolas en forma de tabla.

1 x semana	2 x semana	3 x semana	Cada 15 días	1 x mes

¿En su opinión hay comidas que una mujer embarazada debe o no debe comer? ¿Cuáles son y por qué?

Profundizar los aspectos siguientes de la comida:

El pescado	¿Por qué es bueno?
El hígado	¿Le gusta? ¿Por qué es bueno?
La tortilla	¿Engorda a la mamá? ¿Engorda al niño? ¿Cuánto engorda? ¿Por qué engorda?
El huevo	¿Es bueno o hace daño? ¿Por qué?
El chile	¿Por qué es malo? ¿Qué es el chincual?
Carne de puerco	¿Es buena/mala? ¿Por qué?

H. 13 Composición Familiar

Técnica: *Entrevista con la mujer embarazada*

Comunidad

Identificación del hogar

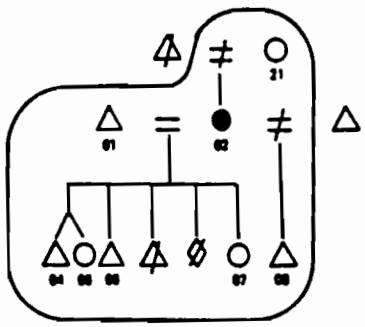
Informante(s)

Fecha(s)

Por medio de una tabla se obtienen los siguientes datos para la informante:

- Nombre
- Edad
- Estado civil
- ¿Vive con el compañero?
- ¿Recibe apoyo económico/emocional del padre del bebé?
- Alfabetismo
- Escolaridad
- Tiempo de residencia en la comunidad
- Lugar de origen: estado, país
- Religión
- Habla algún dialecto
- Ocupación principal
- Número de personas que componen el grupo doméstico
- Número de niños menores de 5 años

Diagrama de Relaciones Familiares y Tabla de Composición Familiar



- △ Hombre
- ○ Mujer
- ▲ ● Ego--la persona que se toma como referencia para las relaciones familiares, generalmente el informante
- Muerto
- Gemelos
- ◇ Sexo desconocido
- Unión formal (casados)
- Unión libre de hecho
- Relación de visita
- Relación disuelta

Cada línea horizontal representa una generación. La línea curva delimita los miembros del mismo hogar. Los números de cada individuo indicados en el diagrama corresponden a los de la tabla, donde se apunta los datos para cada persona (abajo).

Núm.*	Nombre	Edad	Sexo	Educación (Años)	Ocupación	etc.
01	Juan Mendoza	32	M	7	Carpintero	
02	Cristina López de Mendoza	30	F	3	Oficios domésticos	

etc.

* Los números corresponden a los del diagrama.

H. 14 Trabajo e Ingresos Familiares

1. ¿Quiénes de las personas que viven en esta casa trabajan? (Columna 1, nombre de cada individuo.)
2. ¿Qué trabajo hace? (Columna 2)
3. ¿Cuánto gana? (Columna 3)
4. ¿Tienen Uds. algunos otros ingresos o recursos económicos?

   Sí No (Vaya a la pregunta 5.)

   4a ¿De donde vienen estos ingresos?

   4b. ¿Cuántos son estos ingresos por mes?

5. ¿Tienen ahorros?

   Sí No

Tabla de Trabajo e Ingresos

1 Nombre	2 Ocupación	3 Sueldo*			4 No sabe
		Diario	Semanal	Mensual	

* No insista si el individuo no quiere dar esta información.

H.15 Condiciones de la Vivienda

Técnicas: Observación, entrevista

Comunidad

Identificación del hogar

Informante(s)

Fecha(s) de entrevista

Tipo de vivienda
- Sólo una familia
- Dos o más familias

Tipo de propiedad del sitio, de la vivienda (paracaidistas, invasiones, favelas)

Descripción de la vivienda
- Número de cuartos, habitaciones
- Tipo de estructura
- Materiales de las paredes, techo, piso
- Condición de las paredes

Eliminación de excretas (instalación sanitaria)

Eliminación de basura

Abastecimiento de agua

Electricidad

Inventario de bienes (radio, televisión, bicicleta, carro)

Prenatal Health Behaviors in Mexico
UCLA/UABC
September 15, 1989

APPENDIX D. SURVEY INSTRUMENT

PROYECTO PRENATAL DE UCLA-UABC

NUMERO DE IDENTIFICACION: _____ V 1 (3)

FECHA: _____ V 2 (2)

HORA: _____ V 3 (3)

I.D. DEL ENTREVISTADOR: _____ V 4 (2)

ZONA: _____ V 5 (2)

INTRODUCCION

Buenos días, mi nombre es _____. Estoy por parte de la Universidad UABC y con el permiso de la Secretaría de Salud en esta comunidad para realizar una encuesta acerca del embarazo. Estamos entrevistando a mujeres embarazadas, sobre el cuidado del embarazo, la alimentación y problemas de salud que puedan surgir durante el embarazo. También estamos interesados en saber donde usted aprende información acerca del embarazo. Usaremos los resultados de este estudio para desarrollar materiales de información para mujeres embarazadas.

Le queremos pedir el favor de participar en este estudio. Si usted esta de acuerdo en participar, quiero entrevistarla por unos 30 minutos.

Si usted está de acuerdo en participar, le agradezco mucho su colaboración. Su nombre no va a ser utilizado en ningún informe, pero sus ideas y sugerencias pueden ayudar en hacer materiales educativos para mujeres embarazadas. Si usted no desea participar en este estudio le agradezco por su tiempo.

Primero quisiera hacerle unas preguntas acerca se su embarazo, y la atención médica durante el embarazo.

1. Cuántos meses de embarazo tiene Ud en este momento?

_____ ..... ____ V6

Número de meses

2. Cuando sospechó que estaba embarazada fue con alguien (lugar) para que le atendieran?

SI (PASE A LA P. 4) 1
NO 2 V7

3. Porqué no ha ido con alguien para que la atendieran?

_____ V8(2)
_____ V9(2)
_____ V10(2)

(PASE A LA P. 7)

4. A donde fue?

a. LA CRUZ ROJA 1
b. EL SEGURO SOCIAL 2
c. UN CENTRO DE SALUD PUBLICA 3 V11
d. UN MEDICO PARTICULAR 4
e. EL DIF 5
f. El HOSPITAL GENERAL 6
g. OTRA (ESPECIFIQUE): _____ 7

5. Cuántos meses de embarazo tenía cuando fue por primera vez a la consulta?

_____ ..... ____V12(2)
NUMERO DE MESES

86

6. En esa primera visita relacionada con su embarazo que le hicieron?

		SI	NO	
a.	Le mandaron hace una prueba de embarazo? ...	1	2	V13
b.	Le hicieron la prueba de embarazo?	1	2	V14
c.	Tomaron la presión de la sangre?	1	2	V15
d.	Le dijeron que no tomara alcohol?	1	2	V16
e.	Le dijeron que debe de comer algunas cosas durante el embarazo?	1	2	V17
f.	Le recomendaron vacunarse contra el tétano?	1	2	V18
g.	Le dieron vitaminas?	1	2	V19
h.	Le dijeron que no fumara?	1	2	V20
i.	Le hicieron prueba de sangre?	1	2	V21
j.	Le aconsejaron que medicinas no se debe tomar?	1	2	V22
k.	Le dijeron de algunas cosas que no debe de comer durante el embarazo?	1	2	V23

7. Desde esa primera visita o desde que se embarazó, ha ido a otras consultas; Por favor dígame a donde fue y cuántas veces ha ido a cada lugar o persona?

		SI	NO		CUANTAS VECES	
a.	la cruz roja	1	2	.....	___	V24
b.	el Seguro Social	1	2	.....	___	V25
c.	un centro de salud pública	1	2	.....	___	V26
d.	una medico particular ...	1	2	.....	___	V27
e.	el hospital general	1	2	.....	___	V28
f.	una sobadora	1	2	.....	___	V29
g.	su suegra	1	2	.....	___	V30
h.	su mama	1	2	.....	___	V31
i.	farmacia	1	2	.....	___	V32
j.	partera/comadrona	1	2	.....	___	V33
k.	ninguno	1	2	.....	___	V34
l.	otra (ESPECIFIQUE): _____				___	V35

-87

8. Porqué cree Ud. que se debe ir a consulta con un doctor durante el embarazo?
(INDIQUE TODO LO QUE MENCIONA)

a.	PORQUE ASI DICEN_____ (UNA PERSONA) ...	1	V36
b.	PORQUE ME SIENTO MAL	1	V37
c.	PORQUE SALE MEJOR TODO Y ME SIENTO SEGURA...	1	V38
d.	PARA VER SI UNO TIENE ANEMIA	1	V39
e.	PARA VER COMO VIENE EL BEBE	1	V40
f.	PARA VER SI ME HACE FALTA VITAMINAS	1	V41
g.	POR COSTUMBRE.....	1	V42
h.	OTRO (ESPECIFIQUE) _____	1	V43

9. Cada cuántos meses cree usted que se debe ir a la consulta?

_____..... ____V44(2)
NUMERO DE MESES

10. Si Ud. tiene alguna preocupación acerca de su embarazo a quién le pide consejos?
(INDIQUE TODO LO QUE MENCIONA)

a.	SU MAMA?	1	V45
b.	SU SUEGRA?	1	V46
c.	AMIGA?	1	V47
d.	SU MARIDO?	1	V48
e.	SU CUÑADA?	1	V49
f.	UN DOCTOR?	1	V50
g.	SOBADORA	1	V51
h.	FARMACEUTICO?	1	V52
i.	ALGUIEN MAYOR?	1	V53
j.	ALGUIEN DE SU IGLESIA?	1	V54
k.	COMADRONA	1	V55
l.	NADIE	1	V56
m.	OTRO (ESPECIFIQUE) _____	1	V57

88

Ahora quisiera hacerle unas preguntas sobre los movimientos del bebe durante el embarazo.

11. En que mes empezó Ud. a sentir los movimientos del bebe?

_____ ..... ____V58(2)
(MES)

12. Si ya ha sentido regularmente movimientos del bebe y de repente dejan de suceder; que cree Ud. que está pasando?

QUE ESTA DURMIENDO	1	
QUE ESTA ENFERMO	2	
QUE NO ESTA CRECIENDO	3	
QUE ESTA MUERTO	4	
QUE ESTA ENCAJADO	5	V59
QUE ESTA ASFIXIADO EL NIÑO POR EL CORDON ...	6	
QUE ESTA LISTO PARA NACER.....	7	
QUE ESTA INCOMODO EL NIÑO	8	
OTRO (ESPECIFIQUE) _____	9	V60

13. Si una amiga esta embarazada y ya ha sentido movimientos fuertes y le dice que su niño no se ha movido en varios días, que le aconsejaría?

IR AL DOCTOR	1	V61
IR A LA SOBADORA	2	
NADA	3	
OTRO (ESPECIFIQE) _____	4	V62

14. Por que cosa cree ud. que se va a ver a la sobadora durante el embarazo?
(INDIQUE TODO LO QUE MENCIONA)

a.	CUANDO LE DUELE ABAJO.....	1	V63
b.	CUANDO NO SIENTE MOVIMIENTOS.....	1	V64
c.	PARA VER COMO VIENE EL BEBE.....	1	V65
d.	SI EL BEBE ESTA EN MALA POSICION.....	1	V66
e.	PARA SENTIRSE MAS A GUSTO.....	1	V67
f.	OTRA (ESPECIFIQUE) _____	1	V68

89

15. Por qué dicen que se pega el niño?

POR ESTAR ACOSTADA	1	
PORQUE DUERME MUCHO LA MUJER	2	V69
PORQUE LA MUJER NO HACE EJERCICIOS	3	
OTRO (ESPECIFIQUE)_____	4	V70

16. Qué cree usted cuando dicen que el niño se encaja?

QUE VIENE CHIQUITO	1	
QUE ESTA BIEN	2	V71
QUE NO SE ALIMENTA BIEN	3	
OTRO (ESPECIFIQUE) _____	4	V72

17. Porque cree que se encaja un niño en el vientre?

PORQUE EL NIÑO ESTA EN MALA POSICION	1	
ANDA A DISGUSTO LA CRIATURA	2	
POR HABER CARGADO COSAS PESADAS	3	V73
PORQUE YA VA A NACER EL BEBE	4	
PORQUE SE PUEDE ASFIXIAR EL BEBE	5	
OTRO (ESPECIFIQUE) _____	6	V74

18. Qué es lo primero que hace Ud. cuando se le encaja el bebe?

IR CON LA SOBADORA	1	
IR AL DOCTOR	2	
USTED MISMA SE SOBA	3	V75
NADA	4	
OTRO (ESPECIFIQUE) _____	5	V76

19. En que meses hay que tener mas cuidados durante el embarazo?

LOS PRIMEROS TRES MESES	1	
LOS MEDIADOS MESES.....	2	V77
LOS ULTIMOS MESES.....	3	
DURANTE TODO EL EMBARAZO.....	4	
OTRO (ESPECIFIQUE) _____	5	V78

90

20. En que meses cree usted que el embarazo presenta mayor molestias?

LOS PRIMEROS TRES MESES	1	
LOS MEDIADOS MESES.....	2	V79
LOS ULTIMOS MESES.....	3	
DURANTE TODO EL EMBARAZO.....	4	
OTRO (ESPECIFIQUE) _____	5	V80

21. En que meses tiene usted mas miedo durante el embarazo?

LOS PRIMEROS TRES MESES	1	
LOS MEDIADOS MESES.....	2	V81
LOS ULTIMOS MESES.....	3	
DURANTE TODO EL EMBARAZO.....	4	
OTRO (ESPECIFIQUE) _____	5	V82

Ahora le voy hacer unas preguntas sobre el tétano

22. Le han puesto una inyección contra el tétanos anteriormente?

SI (PASE A P. 24).....	1	V83
NO	2	

23. Por qué no ha recibido una inyección contra el tétanos?

DUELE MUCHO	1	
NO SABIA QUE ERA NECESARIO	2	
NO CONFIA EN LAS VACUNAS	3	V84
POR DECIDIA	4	
NO TIENE DINERO	5	
NO HA IDO A CONSULTA	6	

91

Ahora le voy a hacer unas preguntas acerca de lo que come durante el embarazo

24. Cuales son las comidas que usted cree que hacen mas provecho durante el embarazo? (INDIQUE TODO LO QUE MENCIONA)

		SI	NO	
a.	LECHE	1	2	V85
b.	CARNE	1	2	V86
c.	CALDO	1	2	V87
d.	VERDURAS	1	2	V88
e.	PESCADO	1	2	V89
f.	FRIJOLES	1	2	V90
g.	TORTILLAS	1	2	V91
h.	POLLO	1	2	V92
i.	RES	1	2	V93
j.	LENTEJAS	1	2	V94
k.	FRUTAS.....	1	2	V95
l.	HUEVO	1	2	V96
m.	OTRAS _____	1	2	V97

25. Cree Ud. que una mujer embarazada debe comer huevos durante el embarazo?

SI (PASE A P. 27)	1	
NO	2	V98

26. Por qué cree que no los debe comer?

PORQUE HACEN DAÑO	1	
PORQUE SON CALIENTES	2	
PORQUE SON FRIOS	3	V99
POR EL COLESTEROL	4	
OTRO (ESPECIFIQUE) _____	5	V100

27. Cuántos huevos come usted?

_____
NUMERO SEMANALES .....____V101(2)
o

_____
NUMERO DIARIOS

92

28. Me podría decir aproximadamente cuántas tortillas come?

NUMERO SEMANALES ..... ____ V102(2)

o

NUMERO DIARIOS

29. Come Ud. mas tortillas de maíz o de harina?

DE MAIZ	1	V103
DE HARINA	2	

30. Cree Ud. que la harina contiene vitaminas?

SI	1	V104
NO	2	

También quiero hacerle unas preguntas acerca del peso durante el embarazo.

31. Considera que durante el embarazo, hay que comer:

Mas	1	
Igual (PASE A P 33)	2	V105
Menos (PASE A P 33)	3	

32. Porqué considera que hay que comer mas? (INDIQUE TODO LO QUE MENCIONA)

a.	PARA QUE SE ALIMENTE BIEN EL BEBE	1	V106
b.	PARA ESTAR BIEN UNO	1	V107
c.	PORQUE DA MAS HAMBRE	1	V108
d.	PARA COMER POR LOS DOS	1	V109
e.	OTRO (ESPECIFIQUE) _____	1	V110

93

33. La cantidad que ha comido durante su embarazo ha sido :

Mas (PASE A P 35)	1	
Igual (PASE A P 35)	2	V111
Menos	3	

34. Porque ha comido menos?

a. _____ V112(2)

b. _____ V113(2)

c. _____ V114(2)

35. Cuánto peso cree Ud. que una mujer debe aumentar durante el embarazo?

NUMERO DE KILOS ....._____._____ V115(2)

36. Cuánto debe pesar el bebe al nacer?

NUMERO DE KILOS ....._____._____ V116(2)

37. Por que cree Ud. que hay bebes que nacen pesando poco?

POR FALTA DE MOVIMIENTOS	1	
POR FALTA DE ALIMENTACION	2	V117
PORQUE LOS PADRES SON CHIQUITOS	3	
POR FALTA DE VITAMINAS	4	
OTRO (ESPECIFIQUE) _____	5	V118

38. Ud. ha tenido un bebe que nació pesando poco?

SI	1	V119
NO	2	

Ahora le voy a preguntar acerca de los antojos durante el embarazo

39. Porque cree Ud. que a una mujer embarazada le dan antojos?

POR EL EMBARAZO	1	
PORQUE AL BEBE SE LE ANTOJA	2	V120
PARA QUE NO SE LE VENGA	3	
OTRO (ESPECIFIQUE) _____	4	V121

40. Cuando a una mujer embarazada se le antoja algo, debe comerlo?

SI	1	V122
NO	2	

41. Qué pasa si no come los antojos?
(INDIQUE TODO LO QUE MENCIONA)

a.	EL BEBE SALE CON UN GRANO EN LA LENGUA	1	V123
b.	NO PASA NADA	1	V124
c.	EL BEBE NACE MAL	1	V125
d.	EL BEBE LO NECESITA	1	V126
e.	SE PROVOCA EL ABORTO DEL BEBE	1	V127
f.	NACE CON LA BOCA ABIERTA	1	V128
g.	NACEN CHIQUITOS	1	V129
h.	SE LE VIENE EL BEBE	1	V130
i.	OTRO (ESPECIFIQUE) _____	1	V131

42. Ud. sabe que a algunas mujeres se les antoja comer tierra?

SI	1	V132
NO (PASE A P. 44).....	2	

43. Por qué cree Ud. que se les antoja comer tierra?

POR FALTA DE VITAMINAS	1	
POR FALTA DE HIERRO	2	
PORQUE REFRESCA	3	V133
PORQUE SE LE ANTOJA EL BEBE	4	
PORQUE EL BEBE TIENE MUCHA HAMBRE	5	
OTRO (ESPECIFIQUE) _____	6	V134

44. Ud. ha tenido ese deseo?

SI	1	V135
NO	2	

45. Ha tenido Ud. antojos de comer magnesia en cubos?

SI	1	V136
NO (PASE A P. 47).....	2	

46. Cuántos cubos de magnesia ha comido en este embarazo?

_____ Número de cubos de magnesia	____	V137

47. Ha tenido antojos de comer higado durante el embarazo?

SI	1	V138
NO	2	

48. Le gusta el higado?

mucho	1	
algo	2	V139
nada	3	

Ahora le voy a preguntar sobre las vitaminas y el hierro durante el embarazo.

49. Que hacen las vitaminas en su cuerpo?
(INDIQUE TODO LO QUE MENCIONA)

a.	DAN HAMBRE	1	V140
b.	DAN FUERZA	1	V141
c.	HACEN ENGORDAR	1	V142
d.	ALIMENTAN EL CUERPO	1	V143
e.	EVITA QUE SALGA MANCHAS EN LA CARA	1	V144
f.	OTRO (ESPECIFIQUE) _____	1	V145

50. Para que cree Ud. que le sirve el hierro durante el embarazo? (INDIQUE TODO LO QUE MENCIONA)

a.	PARA QUE LE DE APETITO A LA MUJER	1	V146
b.	PARA QUE AMAZICEN LOS HUESOS	1	V147
c.	PORQUE ES BUENO PARA EL BEBE	1	V148
d.	POR QUE ES BUENO PARA EL CUERPO (FORTALEZA)..	1	V149
e.	OTRO (ESPECIFIQUE) _____	1	V150

51. Hasta cuando absorbe (agarra) el bebe hierro durante el embarazo?

LOS PRIMEROS TRES MESES	1	
LOS MEDIADOS MESES.....	2	V151
LOS ULTIMOS MESES.....	3	
DURANTE TODO EL EMBARAZO.....	4	
OTRO (ESPECIFIQUE) _____	5	V152

52. Alguna vez ha recibido una inyección de hierro?

SI	1	V153
NO	2	

53. Alguna vez ha tomado capsulas de hierro durante este embarazo?

SI	1	V154
NO		

91

54. Cree ud. que la anemia en una mujer embarazada es peligroso?

SI	1	V155
NO (PASE A LA P. 56).....	2	

55. Por qué cree ud. que la anemia en una mujer embarazada es peligroso?

_____	V156(2)
_____	V157(2)
_____	V158(2)

56. Por que razones cree usted que da la anemia? (INDIQUE TODO LO QUE MENCIONA)

a.	DEBILIDAD/CANSANCIO.....	1	V159
b.	FALTA DE HAMBRE	1	V160
c.	NO COMER ALGO QUE HACE PROVECHO	1	V161
d.	FALTA DE VITAMINAS.....	1	V162
e.	POR MALA ALIMENTACION	1	V163
f.	OTRO (ESPECIFIQUE) _____	1	V164

57. Qué le pasa a una persona cuando tiene anemia? (INDIQUE TODO LO QUE MENCIONA)

a.	ESTA DEBIL	1	V165
b.	ESTA DELGADA	1	V166
c.	SE SIENTE CANSADA	1	V167
d.	TIENE LOS OJOS AMARILLOSOS	1	V168
e.	ESTA PALIDA	1	V169
f.	SE PUEDE MORIR	1	V170
g.	TIENE DOLORES	1	V171
h.	SE ENFERMA A CADA RATO	1	V172
i.	OTRO (ESPECIFIQUE) _____	1	V173

58. Cree usted que la anemia tiene algo que ver con la sangre?

SI	1	V174
NO (PASE A LA P.60).....	2	

59. Qué pasa en la sangre cuando uno tiene anemia?

NO CIRCULA	1	
SE AGUADA	2	V175
RALA	3	
OTRO (ESPECIFIQUE) _____	4	V176

60. Que cree ud. que se puede hacer para curar la anemia?

TOMAR HIERRO	1	
ALIMENTARSE MEJOR	2	
IR CON EL MEDICO	3	V177
PONERSE O TOMAR VITAMINAS.....	4	
COMER COMIDAS CON HIERRO	5	
OTRO (ESPECIFIQUE) _____	6	V178

El siguiente grupo de preguntas están relacionadas con problemas de salud que pueden surgir durante el embarazo.

61. Cuando se habla de un embarazo de alto riesgo en que le hace pensar? (INDIQUE TODO LO QUE MENCIONA)

a.	EL ABORTO	1	V179
b.	UNA CAIDA	1	V180
c.	NACE DEFORME EL BEBE	1	V181
d.	DEBILIDAD DEL VIENTRE	1	V182
e.	ALGUNA ENFERMEDAD	1	V183
f.	FALTA DE HORMONAS	1	V184
g.	EL SANGRADO	1	V185
h.	NACE EL BEBE ANTES DEL TIEMPO	1	V186
i.	EL PARTO	1	V187
j.	CUANDO SE VA A ALIVIAR	1	V188
k.	EL PELIGRO DE QUE EL BEBE SE MUERA	1	V189
l.	UNO TIENE QUE TENER CUIDADO	1	V190
m.	OTRO (ESPECIFIQUE) _____	1	V191

62. Durante este embarazo le ha subido la presión?

SI	1	V192
NO	2	

63. Cree Ud. que la alta presión en una mujer embarazada es peligrosa?

SI	1	
NO (PASE A LA P. 65).....	2	V193

64. Por qué cree que la alta presión en una mujer embarazada es peligrosa?

_____ V194(2)

_____ V195(2)

_____ V196(2)

65. Que cree ud. que se puede hacer para bajar la presión?

DESCANSAR-REPOSAR	1	
TOMAR MEDICINA	2	
CAMBIAR DE DIETA	3	V197
TOMAR COCA-COLA	4	
NADA	5	
IR CON EL MEDICO	6	
OTRO (ESPECIFIQUE) _____	7	V198

66. Durante este embarazo ha notado que se le hinchan mucho los pies?

SI	1	V199
NO	2	

67. Cree Ud. que mucha hinchazón en una mujer embarazada es peligrosa?

SI	1	
NO (PASE A LA P. 69).....	2	V200

68. Por qué cree que mucha hinchazón en una mujer embarazada es peligrosa?

_____	V201(2)
_____	V202(2)
_____	V203(2)

69. Que cree ud. que se puede hacer en una mujer embarazada para bajar lo hinchado?

LEVANTAR LOS PIES PARA ARRIBA.....	1	
NO COMER SAL	2	
DESCANSAR-REPOSO	3	
IR CON EL MEDICO	4	V204
NADA	5	
SOLO ALIVIARSE	6	
OTRO (ESPECIFIQUE) _____	7	V205

70. Durante este embarazo ha tenido dolor de cabeza muy fuerte?

SI	1	V206
NO	2	

71. Cree ud. que el tener mucho dolor de cabeza en una embarazada es peligroso?

SI	1	
NO (PASE A LA P.73)	2	V207

72. Por qué cree que el dolor de cabeza en una mujer embarazada es peligroso?

a. _____ V208(2)

b. _____ V209(2)

c. _____ V210(2)

73. Que cree ud. que se puede hacer para aliviar un dolor de cabeza muy fuerte durante el embarazo?

TOMAR MEDICINA/ASPIRINA/PASTILLAS.....	1	
DESCANSAR/DORMIR.....	2	
NO COMER SAL.....	3	
TOMAR JUGO DE NARANJA.....	4	
TOMAR CAFE	5	V211
TOMAR TE DE AZAHAR	6	
IR CON EL MEDICO.....	7	
ASPIRINA/PERO NO TOMO POR EL EMBARAZO	8	
NADA	9	
OTRO (ESPECIFIQUE) _____	10	V212

74. Durante este embarazo ha tenido vista borrosa? (como negra, nublado?)

SI	1	
NO	2	V213

75. Cree Ud. que la vista borrosa en una mujer embarazada es peligroso?

SI	1	
NO (PASE A LA P. 77).....	2	V214

76. Por qué cree que la vista borrosa en una mujer embarazada es peligrosa?

a. _____ V215(2)

b. _____ V216(2)

c. _____ V217(2)

77. Que cree ud. que se puede hacer para evitar la vista borrosa en una mujer embarazada?

PONERSE GOTAS	1	
IR CON EL MEDICO	2	
MOJARSE LA FRENTE	3	
COMER BIEN/ALIMENTARSE BIEN	4	V218
TOMAR VITAMINAS	5	
NADA	6	
OTRO (ESPECIFIQUE) _____	7	V219

Ahora le voy a hacer unas preguntas acerca de la enfermedad de la diabetes

78. Cuando Ud. oye la palabra diabetes, en que le hace pensar? (La enfermedad conocida como diabetes, en que se le conoce?)
(INDIQUE TODO LO QUE MENCIONA)

a.	PROBLEMAS EN LA SANGRE	1	V220
b.	CUANDO SE COME MUCHO AZUCAR	1	V221
c.	ALTA AZUCAR	1	V222
d.	OTRO (ESPECIFIQUE)_____	1	V223

79. Tiene Ud. diabetes?

SI	1	
NO (PASE A LA P. 81).....	2	V224

80. Qué hace para controlar su diabetes?

a.	_____	V225(2)
b.	_____	V226(2)
c.	_____	V227(2)

104

81. Cree Ud. que la diabetes en una mujer embarazada es peligrosa?

SI 1

NO (PASE A LA P. 83)..... 2 V228

82. Por qué cree que es peligrosa?

a. _____ V229

b. _____ V230

c. _____ V231

83. Durante este embarazo ha sentido mucha sed?

SI 1

NO 2 V232

84. Cree Ud. que tener mucha sed durante el embarazo puede ser peligroso?

SI 1

NO 2 V233

85. Qué toma cuando tiene mucha sed? (INDIQUE TODO LO QUE MENCIONA)

TOMA AGUA 1 V234

TOMA SODA/REFRESCO 1 V235

JUGOS 1 V236

OTRO (ESPECIFIQUE) _____ 1 V237

Le voy hacer unas preguntas acerca de algunas cosas que pueden suceder durante el embarazo.

86. Durante este embarazo ha tenido dolores en el vientre?

SI 1

NO 2 V23

87. Durante este embarazo ha tenido usted sangrado vaginal (sangrado por abajo)?

SI 1

NO (PASE A LA P. 89)..... 2 V23

105

88. Por que cree usted que le pasó el sangrado vaginal?

POR UN CORAJE	1	
POR UNA CAIDA	2	V240
TENSION NERVIOSA	3	
OTRO (ESPECIFIQUE) _____	4	V241

89. Por que cree usted que algunas mujeres embarazadas tienen sangrado vaginal? (INDIQUE TODO LO QUE MENCIONA)

a.	POR HABER LEVANTADO COSAS PESADAS	1	V242
b.	AMENAZA DE ABORTO.....	1	V243
c.	POR UN CORAJE	1	V244
d.	PORQUE NO SE CUIDAN	1	V245
e.	POR ALGUN MOVIMIENTO BRUSCO	1	V246
f.	OTRO (ESPECIFIQUE) _____	1	V247

90. Cree Ud. que el sangrado vaginal en una mujer embarazada es peligroso?

SI	1	
NO (PASE A LA P. 92)	2	V248

91. Por qué cree que el sangrado vaginal en una mujer embarazada es peligroso?

a.	_____	V249(2)
b.	_____	V250(2)
c.	_____	V251(2)

92. Que cree Ud. que se debe hacer cuando hay sangrado vaginal durante el embarazo?

(INDIQUE TODO LO QUE MENCIONA)

a.	IR AL MEDICO	1	V252
b.	TOMAR UN TE DE CANELA CON YERBA BUENA	1	V253
c.	IR CON LA SOBADORA/COMADRONA	1	V254
d.	IR A LA FARMACIA	1	V255
e.	OTRO (ESPECIFIQUE) _____	1	V256

93. Durante este embarazo ha tenido sangre en la orina?

SI	1	V257
NO	2	

94. Cree usted que tener sangre en la orina en una mujer embarazada es peligroso?

SI	1	
NO (PASE A LA P. 96).....	2	V258

95. Por qué cree que el sangrado en la orina es peligroso?

a.	_____	V259(2)
b.	_____	V260(2)
c.	_____	V261(2)

YA CASI ESTAMOS TERMINANDO SEÑORA , SOLO NOS FALTA UN POCO

El siguiente grupo de preguntas es acerca de los medios de comunicación de los que se aprende información sobre el embarazo.

96. Le voy a leer una lista de los medios de comunicación donde se aprende información sobre el embarazo. Me puede indicar de cuáles de ellos ud. aprendió o ha aprendido información sobre el embarazo? (INDIQUE TODO LO QUE MENCIONA)

televisión	1	V262
la radio	1	V263
los diarios	1	V264
un periódico semanal	1	V265
de folletos	1	V266
de fotonovelas	1	V267
de revistas	1	V268
de parientes (cuales)_____	1	V269
de vecinas.....	1	V270
de amigas.....	1	V271
de comadronas.....	1	V272
del doctor.....	1	V273
de la visitadora social.....	1	V274
de las enfermeras.....	1	V275
de la farmacia.....	1	V276
otro (ESPECIFIQUE) _____	1	V277

97. De todos estos medios de comunicación que ud. me acaba de indicar, (LEER TODOS LOS QUE ELLA MENCIONO EN P.95) me puede decir los cuatro más importantes que ud. considera le dan la mejor información sobre el embarazo. Empiece con:

a.	la más importante: _____	V278
b.	la segunda más importante: _____	V279
c.	la tercera más importante: _____	V280
d.	la cuarta más importante: _____	V281

108

98. Cuando Ud. necesito información sobre el embarazo donde la consiguio?

_____ V282(2)

99. Cuando Ud. necesito información sobre donde ir para obtener consulta acerca del embarazo donde la consiguio?

_____ V283(2)

100. Cuántas horas de televisión mira ud. cada día?

a. durante la semana ..... ____V284(2)

b. durante el fin de semana ..... ____V285(2)

101. Con cuánta frecuencia mira ud. los siguientes programas de televisión?

		NUNCA	(CASI NO) ALGUNAS VECES	TODOS LOS DIAS	
a.	noticias	1	2	3	V286
b.	telenovelas	1	2	3	V287
c.	películas	1	2	3	V288
d.	programas femeninos ...	1	2	3	V289
e.	programas musicales ...	1	2	3	V290
f.	programas infantiles ..	1	2	3	V291
g.	entrevistas	1	2	3	V292
h.	programas de salud	1	2	3	V293
i.	programas de la comunidad	1	2	3	V294

102. Cuáles son sus tres programas favoritos de la televisión?

a. _____ V295(2)

b. _____ V296(2)

c. _____ V297(2)

103. Cuáles son las horas del día que usted mas frecuentemente mira la televisión?

a. POR LA MANANA (6 - 12 a.m)..... 1

b. POR LA TARDE (12 - 4 a.m./p.m)..... 2

c. AL ATARDECER (4- 7 p.m.) 3 V298

d. POR LA NOCHE 4

e. TODO EL DIA 5

104. Cuánto tiempo escucha la radio durante el día?

NUMERO DE HORAS ..... ____ V299(2)

105. Qué tan a menudo escucha usted por la radio?

		NUNCA	(CASI NO) ALGUNAS VECES	TODOS LOS DIAS	
a.	noticias	1	2	3	V300
b.	música(especifique)....	1	2	3	V301
c.	entrevistas.....	1	2	3	V302
d.	servicio comunitario...	1	2	3	V303
e.	radionovela.....	1	2	3	V304
f.	programas religiosos...	1	2	3	V305
g.	programas de salud.....	1	2	3	V306

106. Cuáles son las tres estaciones de radio que usted más escucha?

a. _____ V307(2)

b. _____ V308(2)

c. _____ V309(2)

107. Cuáles son las horas del día que usted mas frecuentemente escucha la radio?

a. POR LA MANANA (6-12 a.m.)..... 1

b. POR LA TARDE (12-4 a.m./p.m.)..... 2

C. AL ATARDECER (4-7 p.m.)..... 3 V310

d. POR LA NOCHE 4

e. TODO EL DIA 5

108. Usted lee frecuentemente fotonovelas?

SI 1

NO (PASE A P. 110)..... 2 V311

109. Cuáles fotonovelas lee usted mas frecuentemente?

a. _____ V312(2)

b. _____ V313(2)

c. _____ V314(2)

110. Hay alguna revista que usted lee frecuentemente?

SI 1 V315

NO (PASE A P. 112)..... 2

111. Cuál revista lee usted mas frecuentemente?

a. _____ V316(2)

b. _____ V317(2)

c. _____ V318(2)

- 111

112. Ud. lee el periódico?

SI	1	V319
NO (PASE A P. 116)	2	

113. Mas o menos cuántos días a la semana lee usted el periódico?

NUMERO DE DIAS ..... ____ V320(2)

114. Cuál es el periódico que usted lee regularmente?

a. _____ V321(2)

b. _____ V322(2)

115. De todas las diferentes secciones del periódico, cuáles son las que usted más lee?

		NO LEE	OJEA	LEE TODO	
a.	la sección cómica	1	2	3	V323
b.	primera página	1	2	3	V324
c.	página editorial	1	2	3	V325
d.	artículos de salud	1	2	3	V326
e.	horóscopo	1	2	3	V327
f.	recetas	1	2	3	V328
g.	anuncios comerciales	1	2	3	V329
h.	diversión	1	2	3	V330
i.	religiosas	1	2	3	V331
j.	noticias _____	1	2	3	V332
k.	otro (especifique)_____	1	2	3	V333

116. Con que frecuencia participa Ud. en los siguientes grupos:

		semanal	mensual	algunas veces al año	nunca	
a.	iglesia/templo	1	2	3	4	V334
b.	juntas de vecinos	1	2	3	4	V335
c.	cundinas	1	2	3	4	V336
d.	sindicatos	1	2	3	4	V337
e.	junta de padres de familia	1	2	3	4	V338
f.	otro (ESPECIFIQUE) _____	1	2	3	4	V339

117. Me podria decir de uno de los siguientes como le gustaria recibir informacion acerca del embarazo:

a.	Television	1	
b.	Radio	2	
c.	Periodico	3	V340
d.	Fotonovela	4	
e.	Revistas	5	
f.	Grupos de comunidad o laborales	6	

Ahora quisiera preguntar su opinión sobre el tamaño de la familia.

118. Cuantos embarazos ha tenido ud., incluyendo este embarazo?

NUMERO DE EMBARAZOS ..... ___ V341(2)

113

119. De estos embarazos que ud. ha tenido, cuantos nacieron vivos?

NUMERO DE HIJOS QUE NACIERON VIVOS ..... ___ V342

120. Cuantos hijos vivos tiene ahora?

NUMERO DE HIJOS QUE AHORA VIVEN ..... ___ V343(2)

121. Quisiera Ud. mas hijos de los que tiene ahora?

SI 1 V344

NO 2

122. En estos tiempos cuántos hijos cree ud. que es bueno tener?

NUMERO ..... ___ V345(2)

123. Cuanto tiempo cree Ud. que es bueno esperar para tener (encargar) el siguiente niño?

NUMERO DE AÑOS ..... ___ V346

o

NUMERO DE MESES .....

Ahora quisiera preguntarle algunas cosas acerca de donde nacieron sus padres y como se identifica usted misma, su pareja y sus padres.

124. Me puede decir cuántos años tiene usted?

AÑOS ..... ___ V347(2)

114

125. Cuantos años en total ha vivido en Tijuana?

NUMERO DE AÑOS ..... ___ V348
o

NUMERO DE MESES ..... ___ V349

126. Donde nació Ud.?

ESTADO O PAIS ..... ___ V350

127. Donde nació su mamá?

ESTADO O PAIS ..... ___ V351

128. Donde nació su papá?

ESTADO O PAIS ..... ___ V352

129. Cuántas personas viven con Ud. ahora en su casa?

NUMERO ..... ___V353(2)

(INDIQUE TODOS, INCLUYA A ELLA)

130. Hasta que año de escuela estudió?

0 1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16 17+

AÑO QUE ESTUDIO ..... _____V354(2)

115

131. Cuál es la situación actual de su trabajo?

trabaja tiempo completo	1	
trabaja tiempo parcial	2	
realiza trabajos cotidianos que surgen	3	
no trabaja o desempleada	4	V355(2)
esta en la escuela	5	
otro? (especifique): _____	6	V356(2)

132. En que exactamente trabaja usted? (Si no trabaja, diga cual fue su último trabajo, por ejemplo: maquiladora, empleada, costurera, mesera, cocinera, etc).

_____ V357(3)

133. Durante el último año (1987), cuántas semanas o meses aproximadamente trabajó?

_____ NUMERO DE SEMANAS o _____ NUMERO DE MESES.....___ V358(2)

134. Durante este embarazo cuando Ud. trabajo fuera de su casa diria Ud. que trabajo mas:

mas tiempo parada	1	
mas tiempo sentada	2	V359
igual	3	

135. Cual es su religión? Es usted:

Protestante	1	
Católica	2	
Testigo de Jehova	3	V360
Otra religión (ESPECIFIQUE) _____	4	
Ninguna (PASE A LA PREGUNTA # 137)	5	

116

136. Qué tan importante es su religión para usted? Diría usted:

Muy importante	1	
Importante	2	V361
Algo importante	3	
Nada importante	4	

Ahora le voy a hacer algunas preguntas acerca del padre del niño.

137. Está usted viviendo con el padre del niño?

SI	1	V362
NO	2	

138. En que situación de hogar esta con el padre del niño?

Unión Libre	1	
Casada	2	V363
Separada o divorciada	3	

139. Con qué frecuencia ve al padre del niño?

Todos los días	1	
Varias veces a la semana	2	
Una o dos veces al mes	3	V364
Menos de una vez al mes	4	
Nunca	5	

140. Me gustaría hacerle algunas preguntas acerca de su esposo/pareja/padre del niño. Cuántos años de escuela terminó su esposo?
(MARQUE EL ULTIMO AÑO QUE COMPLETO)

0	1	2	3	4	5	6	7	8	9
10	11	12	13	14	15	16	17+		

AÑO QUE ESTUDIO ..... ___V365(2)

117

141. Cuál es la situación actual de trabajo de su esposo/pareja?

Trabaja tiempo completo	1	
Trabaja tiempo parcial	2	
Realiza trabajo cotidianos que surgen	3	V366
No trabaja o desempleado	4	
Esta en la escuela	5	
Otro? (ESPECIFIQUE) _____	6	V367

142. En que trabaja exactamente su esposo/pareja? (Si no trabaja qué hacia en su último trabajo, por ejemplo: una fabrica, jardinero, vendedor etc.)

_____ V368(3)

_____

143. Durante el último año, cuántas semanas o meses aproximadamente trabajó su esposo?

_____ _____ V369(3)
NUMERO DE SEMANAS o NUMERO DE MESES

****
* *
* *
* LE AGRADEZCO MUCHO POR SU PARTICIPACION, Y SU TIEMPO. *
* HAY ALGUNA PREGUNTA QUE TIENE ACERCA DE MI *
* O ACERCA DEL CUESTIONARIO? *
* *
* *
****