PN-ABX-171
ISN 34726

CONSOLIDATING THE ARI ETHNOGRAPHIC RESULTS AND DESIGNING THE BEHAVIORAL STRATEGY

Guatemala

January 30 to February 10, 1995

Patricio Barriga

BASICS Technical Directive No: 008-GU-01-012
USAID Contract No: HRN-6006-C-00-3031

TABLE OF CONTENTS

ACKNOWLEDGMENTS v

ACRONYMS vii

I. EXECUTIVE SUMMARY 1
- Recommendations 2
- Follow-up Activities 3

II. PURPOSE OF VISIT 3

III. BACKGROUND 4
- A. The ARI Priority 4
- B. Consultants Previous Trip 4

IV. METHODOLOGY 4

V. TRIP ACTIVITIES 6

VI. PRODUCTS 8

VII. RECOMMENDATIONS 9

VIII. FOLLOW-UP ACTION REQUIRED 9

APPENDICES 11
- APPENDIX A: Suggested Process 13
- APPENDIX B: List of Participants, Two-Week Workshop 19
- APPENDIX C: List of Participants, One-Day Workshop 23
- APPENDIX D: Comportamientos Actuales 29
- APPENDIX F: Analisis De Comportamiento
  - Balanza De Evaluacion Del Comportamiento 43

ACKNOWLEDGMENTS

The ARI behavioral strategy would not have gone very far during this two-week period without the technical contributions of Enrique Molina, Sandra Sáenz, Carlos Quan, Carlota Lucero, Cristina Martínez, Faustina Ordóñez, and Himelda Bulux.

They not only attended the daily work meetings, but also participated enthusiastically in the decision-making process that culminated with the production (in a draft form) of a communications/education plan aimed at the control of infant ARI in Guatemala.

Thanks to USAID in the persons of Pat O'Connor, Jorge Chang, and Francisco Puac, who encouraged this consultant and gave a wider view of the institutional forces at play.

And last but not least, thanks to Rodrigo Bustamante, Víctor Lara, and their Guatemalan colleagues from Clapp & Mayne. They provided this consultant with guidance, a timely debriefing and the needed managerial support.

ACRONYMS

ALRI	Acute Lower Respiratory Infections
ARI	Acute Respiratory Infections
BASICS	Basic Support for the Institutionalization of Child Survival
INCAP	Instituto de Nutrición para Centro América y Panamá
MCH	Maternal and Child Health
MOH	Ministry of Health
PAHO	Pan American Health Organization
ORS	Oral Rehydration Salts
SCM	Standard Case Management
SIIS	Sistema Integrado de Información de Salud (Health Information Integrated System)
TA	Technical Assistance
UDAMIN	Unidad Docente Asistencial Materno Infantil Nacional (National Maternal-Child Teaching Unit)
USAID	United States Agency for International Development
WHO	World Health Organization

I. EXECUTIVE SUMMARY

The purpose of the trip was to assist the MOH in processing the ethnographic research data and, based on those results as well as the ARI norms, prepare the ARI behavioral strategy. An important task of consultant was to provide the ad hoc group with some exposure to the "systematic communications" methodology, which has been successfully applied to public health during the last decade.

Some of the consultant's recommendations from his first trip had been implemented as part of the ARI ethnography conducted by INCAP in four ethnic/geographic zones of Guatemala. Clapp & Mayne has done a good job supervising this research designed to provide community behavioral data as the foundation for a communications strategy. This effort has the potential to help Guatemala significantly reduce infant mortality due to pneumonia.

This consultant conducted two consecutive workshops aimed at meeting the TA goals. The first was a promotional activity that helped participants understand the ethnography and communications methodology. The second, with the ad hoc group, was to design the behavioral strategy.

The purpose of the systematic approach to communications is to achieve positive changes in community behaviors, placing emphasis on preventive activities. It is possible to produce significant changes in the way mothers treat ARI at home and in the way they handle referral in case of pneumonia.

The consultant's main activities were the following:

Design and conduct a one-day workshop for MOH, USAID, NGOs, and Clapp & Mayne personnel in order to share with them the communications behavioral-oriented methodology and to discuss some critical issues in its preparation and implementation.

Assist the National ARI Control Program in the design of a behavioral strategy aimed at reducing infant mortality caused by pneumonia. This was needed to develop communications planning skills among MOH officials.

Development of a consolidated list of community ARI-related "actual behaviors" in order to summarize the ethnographic research results in a manageable form. Results were categorized under the following subtitles: a) mothers' perceptions on ARI symptoms and conditions; b) home treatment/remedies; and c) search for help.

Development of a summarized list of ARI-related "ideal behaviors" (desirable behaviors) based on the official ARI treatment norms (standardized case management). The product was a list of desirable behaviors to be then contrasted with the "actual behaviors" in order

to generate the "feasible behaviors;" this last set of behaviors will serve as the main input to prepare the behavioral strategy.

Select the set of behaviors that will be enforced by the communications effort during the implementation of the communications plan. This was done in order to establish the behavioral basis for the communications strategy and to get a consensus on what to emphasize, when to communicate, and through which channels.

Develop a creative strategy capable of producing meaningful behavioral changes among mothers and caretakers in relation to identifying pneumonia signs and ARI home treatment. This helped the MOH planners visualize the ARI communications process in tangible terms. It also provided a coherent explanation of how messages will be utilized as behavioral change mechanisms.

Develop a social marketing approach which places attention on the product, price, placement, and promotion. This provides a more pragmatic view of the management process and helps participants plan their communications activities in a more creative way.

Recommendations

Complete and edit the "Behavioral Strategy" for MOH official approval. A few chapters still need to be written, like "Previous ARI Investigations Abstracts" and "Training".

Design and develop a controlled quasi experimental pilot intervention in selected high risk health areas, where the behavioral strategy will be tested. In the case of two selected areas (with two or three health centers each), the study could take the form of a multiple base-line study.

Postpone the production of graphics materials until they are pretested with community mothers. The group(s) with whom materials are to be tested should represent the high risk population characteristics: mainly illiterate, very poor, Mayan and Ladino.

Consider the possibility of assigning the responsibility of the ARI behavioral strategy implementation to a reliable MOH office. Since the ARI behavior strategy is of an education/diffusion nature, it should be coordinated by Human Resources, Promotion, or the Health Education Unit.

Utilize the upcoming national epidemiology survey, whose data will be collected in June of this year, as a vehicle to obtain base-line data that will allow the ARI intervention to be evaluated. If still possible, it should include questions on the ARI- related household practices and attitudes towards the health system.

Implement the ARI behavioral strategy within the selected regions and health areas. This will allow more expedient conducting of actions with fewer bureaucratic steps. The degree of participation should be decided about such groups as the Pediatric Society, the Academy of Maya Tongues, the MCH National Teaching Unit, and other private and public entities like the Ministry of Education and its Bilingual Education Program.

Follow-up Activities

1. Clapp & Mayne/Guatemala will provide support to the ad hoc group in charge of completing the ARI "Behavioral Strategy." They still need to meet for one or two days during the upcoming two weeks.

2. The ARI program coordinator should be convinced to wait until a sound validation is done before graphic materials are printed.

3. A national local consultant could be hired for a one-year period to assist the selected health areas on the implementation of the pilot intervention.

4. In order to get the needed MOH support, a presentation should be given to higher MOH officials, once the final document on the ARI behavioral strategy has been finished.

II. PURPOSE OF VISIT

A) Assist INCAP and the MOH ad hoc group in the organization, analysis, and interpretation of the data generated during the first phase of ethnographic data collection.

B) Assist INCAP and the MOH in the reorientation of the data collection strategy for the second stage and in the redesign of the data collection instruments (focus groups and interview guides).

C) Assist key MOH officials in understanding the role of the communications planning stage and the role of formative qualitative research as the main tool for decision-making in defining, among other aspects, the behavioral objectives, the audience segmentation, and the communications strategy, including "positioning".

D) Assist INCAP and MOH personnel in the organization and final analysis of the data generated by the first and second phases of the data collection and preparation for the final report writing.

E) Conduct a two to three day "behavioral analysis" session that will allow the MOH/INCAP team to select the behaviors that will be introduced, modified, or reinforced in order to reduce infant mortality cause by ALRI.

F) Assist in the elaboration of the ARI communications plan, including: creative strategy, social marketing, positioning of "products" (behaviors), management, production of learning aids, training, and budgeting.

III. BACKGROUND

A. The ARI Priority

According to the SIIS, in 1993, ARI became the primary cause of out-patient consultation (28%) for the national health system. This was followed by diarrheal diseases, skin ailments, immunizations and growth monitoring. Pneumonia is now the first cause of infant mortality in Guatemala, and it appears that most of those deaths take place in the household without any contact with the health system.

More than 50 percent of infant deaths occur during the first year, and at least half of those fatalities occur before the child is two months old.

B. Consultants Previous Trip

This consultant was previously contracted to assist the MOH in the design of an ARI ethnography to be conducted by INCAP in four ethnic/geographic zones. Clapp & Mayne subcontracted INCAP to carry out this research. Its purpose was to generate behavioral data to serve as the foundation for the communications strategy that will help Guatemala to reduce infant mortality caused by pneumonia.

As recommended after the one-week consultancy last August, MOH personnel were invited to participate in the data collection. Unfortunately, they could attend neither the instruments preparation meetings nor the field trips to collect data. Planning and decision-making would have been easier if they had participated. This would have given them a sense of ownership. Their involvement is crucial for future activities, and they now seem committed to involvement in the implementation activities.

IV. METHODOLOGY

Communications in public health has evolved rapidly during the last fifteen years. From a rather "institutional-cognitive" approach to a "client-base" behavioral model, communications has changed its management processes and way of approaching communities.

The most promising aspects of these advancements are: a) its emphasis on client needs and resources; and, b) the use of technologies that traditionally belonged to other trades. That is the case of disciplines such as instructional design, social marketing, behavioral analysis, and ethnographic research. Each of these, coming from different fields, have made significant contributions.

The experience of USAID shows that this approach, combined with the improvement of primary health care personnel training, is capable of producing results in a relatively short period of time.

The goal of communications in public health has become the production of positive changes in health behavior that improve health status. It is, basically, a preventive health approach. That is the case for some child survival interventions where, for example, infant diarrhea can be successfully treated with ORS and pneumonia with an antibiotic. In other cases, such as immunizations, the preventive approach takes the form of increasing the demand for products and services which are essential to reduce infant mortality.

Developing new social behaviors and "accelerating" existing ones (growth monitoring and breastfeeding, respectively) could also become child survival communications tasks. In some cases, depending on the behavioral research findings, "disaccelerating" some behaviors could become the communications task. For example, helping child care-takers to avoid purges in case of diarrhea, or going to the "curandero" instead of the health center in case of pneumonia.

Identifying and understanding the target population behavior is critical. In the case of infant ARI in Guatemala, an ethnographic research study was conducted to serve as the main frame of reference for planning the communication/education activities. This study provided what this consultant calls "the good, the bad, and the ugly". It gives planners a quite accurate view of what mothers do (or don't do) when their children get ARI symptoms. More so, it tells planners if mothers perceive ARI signs and symptoms, what these mean to them, and what they do in each case.

The behavioral approach to public health not only makes sense in theoretical terms as a scientific option (it follows the scientific method), but also helps meet program goals by maximizing the use of available resources.

These behavioral changes are measured through formative and, if possible, summative evaluation efforts. Program activities are closely monitored in order to generate timely feedback that helps introduce needed adjustments.

V. TRIP ACTIVITIES

In close communication with Dr. Víctor Lara and Dr. Barry Smith, this consultant developed an agenda, the main activities implemented during the ten day consultancy being the following (See Appendix A, Suggested Process):

1. **Design and conduct a one-day workshop for MOH, AID, NGOs and Clapp & Mayne personnel. (Nebaj Room, Cortijo Reforma Hotel, Guatemala City)**

   Purpose: share with some 25 participants the communications behavioral-oriented methodology and to discuss some critical issues of its preparation and implementation. It included a summarized results presentation of the ethnographic research designed and implemented by INCAP under Anthropologist Sandra Sáenz de Tejada.

   The workshop met expectations of the MOH, and the TA. (See Appendix C).

2. **Assist the National ARI Control Program in the design of a behavioral strategy aimed at reducing infant mortality caused by pneumonia. This took place through a nine-day meeting with the ad hoc group. (See Appendix B)**

   Purpose: develop a number of communications planning skills among MOH officials who will be in charge of implementing and monitoring the strategy. At the same time, assist the MOH in the decision-making process.

   At first, participants were a little shy since the design process calls for a lot of creative discussion and, some times, open debate. But after the second day, they were more at ease with each other and with the participatory decision-making and team building process. A variety of techniques were used accordingly with the design needs. Small task group, brainstorming, morphological analysis, and decision trees, among other techniques were utilized during the two-week period.

3. **Development of a consolidated list of community ARI related "actual behaviors."**

   Purpose: summarize the ethnographic research results in a manageable form. Results were categorized under the three following categories:

   a) mothers' perceptions of ARI symptoms/conditions;
   b) home treatment/remedies; and,
   c) search for help.

   This was probably the most difficult and time-consuming activity, but everybody felt quite satisfied when the list was completed. The process consisted of identifying, within the ethnographic data, the specific ARI related perceptions, practices, beliefs and attitudes

and, then, categorizing them. (See Appendix D: "Comportamientos Actuales," Actual Behaviors).

Once the "actual behaviors" were obtained, the group prepared a series of charts with three additional columns after each behavior: a) rationale for behavior; b) perceived consequences; and c) cost/benefit. These charts will be presented in the final document; they are still at the draft stage.

4. **Development of a summarized list of ARI related "ideal behaviors" (desirable behaviors) based on the official ARI treatment norms (standardized case management).**

Purpose: to prepare a list of desirable behaviors to be then contrasted with the "actual behaviors" in order to generate the "feasible behaviors," this last set of behaviors will serve as the main input to prepare the ARI behavioral strategy.

From the group work, it was clear that there is no consensus yet among Guatemalan physicians about how to manage certain ARI conditions like infant fever, cough, etc. During the pilot intervention, it will be crucial to count on some MOH basic agreement about the most important medical procedures.

5. **Select the set of behaviors that will be enforced by the communications effort during the implementation of the communications plan.**

Purpose: establish the behavioral basis for the communications strategy and a consensus on what to emphasize, when to communicate, and through which channels.

The "Evaluation Behavioral Scale" (Appendix F) was applied to the set of desirable behaviors in order to select what the group thought was realistic and feasible to accomplish in a given period of two to three years. As said before, it was difficult to overcome this stage for lack of consensus. Nevertheless, a working agreement was obtained, but still needs some more discussion before it is final.

6. **Develop a creative strategy capable of producing meaningful behavioral changes among mothers and caretakers in relation to pneumonia signs identification and ARI home treatment.**

Purpose: help the MOH planners visualize the ARI communications process in tangible terms; it will also provide a coherent explanation on how messages will be utilized as behavioral change mechanisms.

This activity was initiated, but could not be completed because of lack of available time. Previous activities took more time than foreseen.

7. **Develop a social marketing approach which places attention on the product, price, placement, and promotion.**

Purpose: to provide a more pragmatical and non-conventional view of the management process and to help participants plan their communications activities in a more creative way.

This activity also needs some more work. A few additional decisions have to be made. How is the product (antibiotics) going to be acquired by mothers whose children have pneumonia symptoms? What are the delivery systems? Would they be willing to pay the price of the antibiotic?

VI. PRODUCTS

1. An ARI control behavioral strategy plan, in draft form, which emphasizes the early recognition of pneumonia and timely referral. The strategy includes behavioral objectives, audience segmentation, a social marketing analysis, a creative strategy, and the message stages.

2. The ethnographic research results organized and translated into behavioral statements ready to be processed as inputs for the ARI communications strategy.

3. A list of "desirable behaviors" (ideal behaviors) that were developed from the "ARI Standardized Case Management Norms" written by the MOH with PAHO/WHO and Clapp & Mayne assistance.

4. An ad hoc working team established for the design and development of the ARI behavioral strategy. The team includes MOH officials that belong to the MCH Division, the Human Resources Division, and the Promotion Section.

5. A consensus among the MOH key players on the behavioral methodology to be used for planning and implementing the ARI control communications strategy. It includes an active understanding of the role of qualitative research in the planning stage and also as a tool for monitoring.

6. The Deputy Director General support to the communications strategy obtained. She was informed by participants and Dr. Víctor Lara about the accomplishments and the work-meeting processes. This may substantially help to maintain institutional support and follow-up.

VII. RECOMMENDATIONS

1. Complete and edit the "Behavioral Strategy" in order to obtain the MOH official approval. A few chapters still need to be written, like "Previous ARI Investigations Abstracts" and "Training," but the most important sections have already been written by participants.

2. Design and develop a controlled quasi-experimental pilot intervention in selected high risk health areas, where the behavioral strategy will be tested. In the case of two selected areas (with two or three health centers each), the study could take the form of a multiple base-line study. Intervention should include training personnel (MOH and community), use of prototype materials, training for mothers, and information for fathers and community leaders.

3. Postpone the production of the graphic materials until they are pretested with community mothers. The group(s) with whom materials are to be tested should represent the high-risk population characteristics: mainly illiterate, very poor, Mayan and Ladino.

4. Consider the possibility of assigning the responsibility of the ARI behavioral strategy implementation to a MOH reliable office. Since the ARI behavior strategy is of a rather education/diffusion nature, it is recommended that it should be coordinated by the Human Resources, Promotion, or the Health Education unit. One option could be establishing an office where personnel from those units are assigned. Another option is to implement it directly with the selected area personnel and working through the General Directorate.

5. Utilize the upcoming national epidemiology survey, whose data will be collected in June this year, as a vehicle to obtain base-line data that will allow the ARI intervention to be evaluated. If still possible, it should include questions on the ARI-related household practices and attitudes towards the health system.

6. Implement the ARI behavioral strategy within the selected regions and health areas. This will allow a more efficient way of conducting actions with less bureaucratic steps. It should be decided about the degree of participation of such groups as the Pediatric Society, the Academy of Maya Tongues, the MCH National Teaching Unit, and other private and public entities like the MOE and its Bilingual Education Program.

VIII. FOLLOW-UP ACTION REQUIRED

1. C&M should provide support to the ad hoc group in charge of the preparation of the ARI "Behavioral Strategy." They have to meet for one or two days during the coming two weeks in order to complete the sections that are, at the moment, in the process of being written.

2. The ARI Program Coordinator should be convinced that it is worth it to wait until a sound validation is done before graphic materials are printed.

3. A national local Consultant should be hired for a one-year period to assist the selected areas in the implementation of the pilot intervention. This person should have a degree in medical anthropology and experience in the "systematic communication" process. Or he/she should have a degree in social communication and have experience in formative evaluation. In both cases, the Consultant must have some experience in social development management and should be willing to live in Xela, Cobán, or Quiché.

4. Copies of the executive summary should be delivered to MOH higher officials, once the final document of the ARI behavioral strategy has been finalized. In order to obtain the MOH policy level support, it would be advisable to make a well-prepared presentation of the plan the those officials. PAHO and UNICEF officials in charge of MCH programs should be invited.

APPENDICES

APPENDIX A

Suggested Process

Appendix A

MEMORANDUM

PARA: Víctor Lara
Clapp & Mayne/Guatemala

DE: Patricio Barriga
BASICS/Wasington

ASUNTO: **Elaboración de la "Estrategia de Comportamiento para el Control deIRA.**

FECHA: 01 de febrero de 1995

****

Después del Taller del día de ayer, que creo que fue exitoso, me permito sugerir un proceso de trabajo que culmine con la formulación de la "Estrategia de Comportamientos para el Control de IRA". Este título, acertadamente sugerido por ti, pone a los participantes en el contexto de un esfuerzo dirigido a obtener resultados concretos, y no sólo producción de documentos para la lectura y discusión.

Mi expectativa es que, aunque sea a manera de borrador, logremos elaborar la "Estrategia del Comporatamiento" para el día viernes 10 de febrero.

Se acordó, con el Dr. Carlos Quan y el Dr. Enrique Molina, continuar la reunión de consulta con los miembros de la Academia de Lenguas Mayas el día 02 de febrero de 1995 en el mismo Hotel Cortijo Reforma. Su participación ha sido positiva y forma parte del proceso de formulación de la estrategia..

Hoy me reuniré, por sugerencia de Pat O'Connors, con el Licenciado Francisco Puac, Asistente de Programas de la AID. Según Pat, él me ayudará a comprender la problemática lingüística y cómo ésta afecta nuestro trabajo de planificación.

Adjunto: "Proceso Sugerido para la Formulación de la Estrategia de Comportamiento para el Control de IRA en Guatemala"
(Borrador)

13

PROCESO SUGERIDO PARA LA FORMULACION DE LA
"ESTRATEGIA DE COMPORTAMIENTO PARA EL CONTROL DE IRA"

Consultor BASICS: Patricio Barriga

1. Identificación y ordenamiento de los comportamientos actuales por grupo étnico. Incluye la determinación de similitudes y diferencias en percepción de síntomas de gravedad de las IRA.

   Producto: "Cuadro de Comportamientos Actuales" (Qué hacen, por qué lo hacen y consecuencia del comportamiento).

2. Conocimiento y análisis de la "propuesta de salud". Esto es, información del equipo de trabajo acerca de las normas IRA y de las actividades realizadas por el programa de control del IRA a la fecha.

   Producto: Equipo informado sobre los particularidades médicas del manejo de los IRA en Guatemala y sus implicaciones de comportamiento de los proveedores y de la comunidad.

3. Análisis de Comportamiento. Es decir contrastar los comportamientos (haceres, pensares y sentires) provenientes de la investigación con las conductas sugeridas por las normas.

   Producto: Comportamientos seleccionados como insumo para la elaboración de la "Estrategia de Comportamiento para el Control de IRA".

4. Análisis de Productos/Servicios. Determinar el potencial del sistema de salud y la factibilidad de satisfacción de la demanda de consulta. Esta demanda será dirigida al médico, enfermeras y/o el promotor comunitario que maneja el antibiótico de elección.

   Producto: Un protocolo de los asuntos críticos relacionados con el posible incremento de la demanda de servicios y de antibióticos.

5. Estrategia Creativa. Incluye la proyección hacia el futuro del proceso que toma lugar en la comunidad cuando se presenta un caso de neumonía infantil.

   Producto: Esquema del proceso de manejo de las IRA en la comunidad y la referencia temprana.

6. Sistema de Adopción por Gratificaciones del Comportamiento. Una vez seleccionados los comportamientos que van a ser creados y/o fortalecidos, se identificarán cuáles son las principales consecuencias alentadoras de esos comportamientos.

   Producto: Listado de comportamientos con sus antecedentes y consecuencias.

7. Programa de Capacitación. Tanto el personal comunitario será capacitado en normas IRA y en manejo de la estrategia del comportamiento.

   Producto: Plan de Capacitación para Promotores y personal institucional.

8. Educación Interpersonal para la Comunidad. Se establecerán los contenidos de lo que el personal de salud, especialmente médico y enfermeras, ha de compartir con las madres de niños menores de 5 años durante la consulta.

   Producto: Mínimos Programáticos. (Contenidos indispensables para la capacitación)

9. Medios de Comunicación Colectiva. Si es pertinente, se establecerá el rol de la radio, la televisión y la prensa para el apoyo a la campaña inicial.

   Producto: Plan de uso de la comunicación colectiva para el control de IRA.

10. El Componente Gerencial. Incluye los aspectos de jefatura, administrativos y logísticos que requieren educación y apoyo para la ejecución del plan.

    Producto: Uncapítulo escrito sobre este tema.

11. Presupuesto Ilustrativo. En el cual se estipularán los gastos de producción, movilización, prensayo de materiales y costo de emisión.

    Producto: Presupuesto (Borrador)

Guatemala, 01/02/95

APPENDIX B

List of Participants
Two-Week Workshop

16

Appendix B
Two-Week Workshop List of Participants

The following persons attended the extended meeting of two weeks which included the presentation/analysis of the ARI etnographic research and the "behavioral strategy" design.

Dr. Enrique Molina, National ARI Control Program Coordinator, MOH

Ms. Cristina Martínez, Human Resources Division, MOH

Ms. Carlota Lucero, Difussion (Promotion) Section, MOH

Dr. Sandra Sáenz, INCAP Anthropologist

Mrs. Faustina Bulux, INCAP researcher

Ms. Himelda Ordóñez, INCAP researcher

Dr. Carlos Quan, Clapp & Mayne ARI Specialist

APPENDIX C

List of Participants
One-Day Workshop

Appendix C
One-Day Workshop List of Participants

Dr. Daniel Salazar, Rural Health Coordinator, Fundación Behrhorst, Chimaltenango

Mr. Nazario Cojtí, CIRMA, Antigua Guatemala

Mr. José Sanic Chanchabal, Lingüistic Coordinator, Academia de Lenguas Mayas

Mr. Andrés Cuz Mucu, Academia de Lenguas Mayas

Dr. Rafael Haeussler, Research Unit Chief, MOH

Dr. Jorge Chang, Project Officer, AID

Mr. Francisco Puac, Health Office, AID

Ms. Elena Hurtado, Researcher, INCAP

Mr. Francisco Javier Sasvin, PAYSA Project

Ms. Mónica Alegría, Agencia de Publicidad

Dr. Enrique Molina, National ARI Control Program Coordinator, MOH

Ms. Cristina Martínez, Human Resources Division, MOH

Ms. Carlota Lucero, Difussion Section Head, MOH

Dr. Sandra Sáenz de Tejada, Research Anthropologist, INCAP

Mrs. Faustina Bulux, Researcher, INCAP

Ms. María Himelda Ordóñez, Researcher, INCAP

Dr. Carlos Quan, Local Health Advisor, Clapp & Mayne

Dr. Víctor Lara, Health Advisor, Clapp & Mayne

Dr. Junio Robles, Official, INCAP

Mr. Marco Tulio López, Advisor, Project PAYSA

Mr. Manfredo Pacheco, Manager, Grupo CGS

Ms Leticia Carranza, Gestora, Clapp & Mayne

TALLER

"ESTRATEGIA DE CAMBIO DE COMPORTAMIENTOS EN IRA: PUNTO DE PARTIDA PARA LA DISMINUCIÓN DE LA MORTALIDAD INFANTIL EN GUATEMALA"

AGENDA DE TRABAJO

FECHA: 31 de enero, 1995

LUGAR: Hotel Cortijo Reforma, Salón Nebaj, Av. Reforma

COORDINACIÓN: Dr. Enrique Molina, Coordinador del Programa Nacional de Control de Infecciones Respiratorias Agudas (IRA)

ASISTENCIA TÉCNICA: Clapp and Mayne, Inc., BASICS, INCAP, AID.

09:30 Bienvenida a los participantes - E. Molina

09:45 Presentación de los participantes - E. Molina

10:00 Objetivos del taller - V. Lara

10:15 Proceso de formulación de la estrategia de cambios de comportamiento para el controlde IRA - P.Barriga

10:45 Presentación de resultados de la Investigación Etnográfica:
- Sandra Sáenz

- Objetivos
- Metodología
- Hallazgos

12:30 Almuerzo

13:30 Discusión en grupos para determinar comportamientos específicos prevalentes en áreas de estudio.

- Identificación de neumonías, respiración acelerada, tiraje.
- Signos de alarma
- Tratamiento casero
- Utilización de servicios de salud

14:30	Presentación de trabajo grupal
15:30	Cierre

APPENDIX D

Comportamientos Actuales

Appendix D

COMPORTAMIENTOS ACTUALES

Lo que la comunidad hace piensa y siente, en la actualidad, acerca de las infecciones respiratorias agudas en niños menores de un año.

A continuación se enumeran los "haceres, pensares y sentires" que prevalecen entre las madres de los infantes guatemaltecos de las cuatro regiones donde se llevó a efecto la consulta etnográfica. Estas regiones pertenecen a las áreas linguísticas k'iché, k'ekchí, kac'chikel y castellano.

En este listado sólamente constan las conductas cuya prevalencia es de más del 50% entre las personas entrevistadas. Cuando una conducta se circunscribe a una de las cuatro áreas señaladas, entonces se indica el nombre del sector lingüístico o geográfico entre paréntesis. Asímismo, se señala la porción de la población que exhibe tal o cual comportamiento.

Para facilitar el ejercicio de "Análisis de Comportamiento" se han ordenado estos "haceres, pensares y sentires" en tres categorías:

- percepción de síntomas,
- tratamiento en el hogar, y
- búsqueda de ayuda.

Al finalizar el listado de "Comportamientos Actuales" se presenta un Glosario que se encuentra en proceso de elaboración y que pretende ser de guía para el equipo de trabajo que se encuentra formulando la Estrategia de Comportamiento para el Control de Ira en Guatemala".

LISTADO DE COMPORTAMIENTOS ACTUALES

Percepcion de síntomas de IRA

1. **La inapetencia e irritabilidad del niño, son de los primeros síntomas que las madres perciben.**

2. **Ante la inapetencia e irritabilidad del niño la madre suele preocuparse, pero no toma medida alguna.**

3. **Los "moquitos pura agua" (mocos claros) no son vistos como enfermedad.**

4. **La tos preocupa casi siempre.**

5. **Las madres distinguen dos tipos principales de tos: tos reseca y tos madura.**

6. **La tos seca y seguida es causa de mayor preocupación: "se puede morir el niño."**

7. **La tos madura (expectoración) tranquiliza a la madres: "la enfermedad está por salir."**

8. **La tos seca con "hervor de pecho" preocupa a la madre (El Progreso).**

9. **Existe "fiebre por fuera" y "fiebre por dentro."**

10. **La madre estima si la fiebre es alta o baja, tocando al niño en la frente, el cuello y otros lugares del cuerpo.**

11. **El niño que se pone muy frío está en mucho peligro y lo calientan de diversas maneras.**

12. **Al niño enfermo que está frío lo abrigan con trapos calentados en las brasas, con frotaciones de kerosina, alcohol, "plantillas de café."**

13. **La percepción de la respiración varía por comunidad. En el area k'iche' no se ve la respiración rápida ("aninac") como señal de peligro.**

14. **Las madres se preocupan cuando al niño le cuesta respirar y "se ahoga" o "se alcanza" (zonas ladina, kekchi, kaqchikel).**

15. **La dificultad al respirar es considerada más grave que la respiración acelerada.**

16. El hervor de pecho ("olla de tamales") es vista como una señal de peligro medio en la zona maya y de alto peligro en zona ladina.

17. El "cecido" o "fatiga" (jadeo con fiebre) es visto como señal de alto peligro.

18. La respiración lenta es considerada de peligro extremo (zonas indígenas). Es signo de muerte inminente.

19. Los ruidos al respirar no son bien reconocidos.

20. El "tzir-tzir" (un ruido en la garganta o pecho) es considerado una señal de peligro, cuando está asociado a la tos seca (zona k'iche').

21. El estridor (jas-jas, jor-jor) y la sibilancia ("silbido", "pitillo") son poco reconocidos como señales de peligro.

22. Los moquitos amarillos, por sí solos, no preocupan.

23. Los moquitos amarillos acompañados de tos y fiebre preocupan más.

24. Los mocos verdes son considerados signo de "infección", como el "costipado" de los adultos.

25. Ponerse morado (o ponerse azul-verde, en los idiomas mayas) es signo de muerte inminente.

26. El no poder mamar es considerado signo de mucha gravedad.

27. Los "ojos entelados" o "trabados" es señal de mucha gravedad.

28. El niño que, estando enfermo llega a "hablar solito", está muy grave.

29. Los "ataques" o convulsiones son signo de gravedad.

30. Si el niño queda "privado" (letárgico, inconsciente, anormalmente somnoliento) está muy grave.

31. La somnoliencia en los niños menores de 3 meses es frecuentemente ignorada, pues se espera que los niños de esta edad duerman casi todo el tiempo.

32. El dolor de oído no es percibido como síntoma de IRA ni se lo ve asociado con IRA.

33. **La picazón en la garganta es de gravedad moderada y puede evolucionar a una condición más grave: "garganta tapada."**

34. **La "garganta tapada" es una condición de gravedad porque no permite al niño tragar.**

35. **Las madres, por lo general, no observa el signo de tiraje.**

36. **Un número reducido de madres observa que se le "brincan las costillas" (tiraje intercostal) y "que se le mueve/hunde el hoyito de la garganta" (tiraje supraclavicular).**

Tratamientos Caseros

1. **Un tercio de las entrevistadas en áreas indígenas utilizan remedios caseros.**

2. **En las áreas ladinas la gran mayoría de madres utilizan remedios caseros.**

3. **Los remedios caseros más conocidos son las infusiones herbales, grasas animales y frotaciones.**

4. **En casos de tos, dan infusiones herbales (manzanilla, eucalipto, tomillo, yerbabuena, bugambilea, miel, zauco, canela, y otros).**

5. **Para la tos dan fricciones con unguentos comerciales (vicks, gms, balsámico, grasas animales y otros).**

6. **Una minoría de madres (<5%) compra jarabes para la tos en la farmacia.**

7. **El catarro no es tratado. Poquísimas madres limpian la nariz con la mano o el delantal.**

8. **Con la nariz tapada el niño no puede mamar y la mamá lo interpreta como inapetencia del niño o que ya no quiere pecho.**

9. **La imposibilidad de succionar provoca, en ocasiones, el destete temprano del niño.**

10. **Para la fiebre utilizan fricciones de alcohol, guaro, "gas," tabaco y lienzos húmedos (agua o alcohol).**

11. Algunas madres ladinas utilizan bolas de algodón empapadas en agua, alcohol o alcanfor debajo de las axilas para "chupar" la fiebre.

12. Como un tercio de madres mayas usa aspirina para bajar la fiebre.

13. Un 80% de madres utiliza aspirina para bajar la fiebre de los niños en áreas ladinas.

14. Casi todas las madres en El Progreso usan acetaminofén para bajar la fiebre del niño.

15. La automedicación de antibiótios es muy limitada.

16. Algunas madres consideran que el "cecido" y la "fatiga" pueden ser tratados en casa con infusiones y fricciones.

17. En las áreas ladinas se acostumbra dar baños de "aguas curadas" para evitar recaídas.

18. Algunas madres k'iche' aplican orina en el oído para calmar el dolor.

19. En las áreas k'iche' y kaqchikel las madres introducen el dedo en la garganta para provocar náusea y que el niño vomite las flemas.

20. El niño con fiebre es demasiado arropado, "para que no le dé el aire."

21. Al niño con fiebre se le suspende el baño.

22. Las madres suspendan los alimentos "fríos" (aguacate, naranja, frijol, sandía, y otros), pues se considera que producen más tos.

23. Las madres suspendan las bebidas frías (baja temperatura), pues consideran que irritan la garganta o que pueden producir una recaída.

Búsqueda de Atención

1. Las madres no buscan atención en la presencia de tiraje porque no lo observan.

2. La respiración acelerada no incita a la búsqueda inmediata de atención.

3. En Ciudad Vieja (área ladina) las madres esperan 1.9 días del inicio de la respiración acelerada para buscar atención biomédica.

4. En El Progreso, la mitad de las madres entrevistadas buscaron atención biomédica el mismo día en que empezó la respiración acelerada (localmente conocida como "fatiga"). En Comalapa (k'ekchí) lo hizo el 20% y en las otras áreas indígenas lo hizo menos del 5%.

5. Las madres (en un 50%) dicen que el servicio de salud más consultado para IRA es el centro/puesto de salud local.

6. En Ciudad Vieja (área ladina) sólo el 8% prefiere ir al centro/puesto de saludlocal para consultar en caso de IRA infantil.

7. Hay una tendencia de las madres a utilizar menos y menos los puestos/centros de salud porque, en diferentes maneras, no resuelven sus problemas, "por el mal trato, por estar frecuentemente cerrados y porque no dan medicamentos."

8. Como segunda eleción, cuando el niño tiene tos, buscan ayuda con el médico y con la enfermera privados.

9. Los síntomas que más incitan a la búsqueda de atención son la tos y la fiebre alta.

10. La frecuencia respiratoria acelerada NO es un signo que incite a las madres a buscar atención.

11. Otros signos y síntomas menos mencionados y que incitan la búsqueda de atención son la cianosis, convulsiones, ruidos en el pecho o la garganta, estar "privado," el "hervor de pecho" y la inhabilidad de mamar.

12. La tos interpretada como "ojo," "mollera caída" o como producto del "acuas am" es tratada por curanderos y comadronas.

13. La utilización de la farmacia y del curandero es relativamente baja.

Glosario

acuas am	=	tela de araña (en la garganta y los pulmones)
aguas curadas	=	agua con hierbas para bañarse
aninac	=	rápido, en k'iché
brincan costillas	=	tiraje intercostal
cecido	=	respiración con seseo
chupar	=	absorber
estar privado	=	estar inconsciente, aletargado
fatiga	=	jadeo con fiebre
guaro	=	aguardiente
gas	=	kerosene
de la garganta	=	tiraje intraclavicular
jas-jas	=	ruido al respirar
jir-jir	=	ruido al respirar
jo-jor	=	ruido al respirar
mollera caída	=	fontanela deprimida
olla de tamales	=	sonido como hervor
ojos entelados	=	ojos torcidos hacia arriba
mal de ojo	=	efecto dañino producido con o sin intención por la mirada intensa
pitillo	=	sonido agudo
plantillas de café	=	café molido puesto en la planta del pie y sujetado con periódico o calcetín

silbido	**=**	**cuando la respiración suena como silvar**
tzir-tzir	**=**	**ruido al respirar**

APPENDIX E

Formato Para Resumen De Investigacion Disponible Sobre IRA

Appendix E

FORMATO PARA RESUMEN DE INVESTIGACION DISPONIBLE SOBRE IRA

Los miembros del equipo ad hoc efectuarán una revisión documental sobre las investigaciones relacionadas con IRA en Guatemala. Elaborarán un resumen de cada una de ellas y utilizarán el siguiente formato.

Título de la investigación

Objetivo de la investigación

Objetivos específicos

Método

- Muestra
- Población
- Técnicas

Hallazgos

Discusión

Conclusiones

Recomendaciones

APPENDIX F

Analisis De Comportamiento
Balanza De Evaluacion Del Comportamiento

Appendix F

ANALISIS DE COMPORTAMIENTO
BALANZA DE EVALUACION DEL COMPORTAMIENTO

A. APROXIMACIONES DE PRACTICAS ACTUALES

0. No se está haciendo nada parecido
1. Una práctica existente es algo parecida
2. Una práctica existente es bastante parecida
3. Una práctica existente es similar
4. Varias prácticas existentes son similares
5. Varias prácticas existentes son muy similares

B. COMPLEJIDAD DEL COMPORTAMIENTO

0. Demasiado complejo
1. Involucra gran cantidad de elementos
2. Involucra muchos elementos
3. Involucra varios elementos
4. Involucra pocos elementos
5. Involucra un elemento

C. APOYO MEDICO

0. Las normas oficiales se oponen
1. No se practica y no se entiende
2. No se practica pero se conoce y se comprende
3. Práctica limitada, pero no muy bien comprendida
4. Práctica limitada, pero ampliamente aceptada
5. Práctica común y ampliamente aceptada

D. SENSIBILIDAD A LOS MEDIOS MASIVOS

0. No puede ser discutido a través de los medios masivos
1. Puede ser mencionado indirectamente por los medios masivos
2. Puede ser mencionado, pero normalmente no se hace a través de los medios masivos
3. Puede ser discutido por los medios masivos, pero sólo dentro de ciertos límites

4. En la actualidad ya se menciona y se discute en los medios masivos, pero limitadamente
5. Se discute abiertamente en los medios masivos

E. REQUERIMIENTOS DE RECURSOS

0. Requiere recursos externos amplios y costosos
1. Requiere recursos que están disponibles sólo para una minoría de la población
2. Requiere recursos disponibles a un costo moderado
3. Puede ser adquirido a bajo costo
4. Requiere sólamente recursos disponibles
5. No requiere de recursos externos

F. IMPACTO DEL COMPORTAMIENTO EN LA SALUD

0. Ningún impacto en el problema (identificado) de salud
1. Poco impacto
2. Algún impacto
3. Impacto significativo
4. Impacto muy significativo
5. Elimina el problema (identificado) de salud

G. CONSECUENCIAS POSITIVAS DEL COMPORTAMIENTO

0. Ninguna que la madre pueda percibir
1. Escasas consecuencias perceptibles
2. Algunas consecuencias
3. Consecuencias significativas
4. Consecuencias muy significativas
5. Consecuencias perceptibles en alto grado

H. COSTO PARA ADOPTAR EL COMPORTAMIENTO

0. Requiere de recursos que no están disponibles o requiere de un esfuerzo irrealizable.
1. Requiere de recursos considerables o de un alto nivel financiero.
2. Recursos o esfuerzos significativos.
3. Algún recurso y esfuerzo.
4. Pocos recursos y poco esfuerzo

5. Requiere sólo de recursos existentes

I. COMPATIBILIDAD CON PRACTICAS EXISTENTES

0. Totalmente incompatible
1. Incompatibilidad muy significativa
2. Incompatibilidad significativa
3. Alguna incompatibilidad
4. Poca incompatibilidad
5. Ninguna incompatibilidad

J. FRECUENCIA DEL COMPORTAMIENTO

0. Debe realizarse con una frecuencia demasiado alta para obtener algún beneficio
1. Debe hacerse cada hora
2. Debe hacerse varias veces al día
3. Debe hacerse a diario
4. Debe hacerse cada cierto número de días
5. Debe hacerse ocasionalmente y aún así obtener un resultado significativo

K. PERSISTENCIA

0. Requiere cumplimiento a lo largo de períodos demasiado extensos (irrealizable)
1. Requiere cumplimiento a lo largo de un período bastante sustancial (un mes)
2. Requiere cumplimiento a lo largo de una semana
3. Requiere cumplimiento por varios días
4. Requiere cumplimiento por un día
5. Puede lograrse en un breve período

L. OBSERVACION

0. No puede ser observado por un extraño
1. Es muy difícil de observar
2. Es difícil de observar
3. Es observable
4. Es fácil de observar
5. No puede pasar desapercibido