DIABETES IN MORELIA: A CASE STUDY ON THE CULTURAL FRAMING OF DIABETES IN MEXICO

By

Everett L. Long

(Under the direction of Jeffery K. Springston)

ABSTRACT

This case study combines qualitative and quantitative frame analysis methods on the issue of diabetes in Morelia, Mexico, for use in an effective health communications campaign. On-site interviews were conducted with local health professionals, journalists who cover the health beat, and people with diabetes and family to elicit stories, descriptions, and concerns that would be relevant in creating such a campaign. Content from in-depth interviews were categorized and analyzed as either a public health frame or socio-cultural schema. The categories were established in previous studies through content analysis of newspapers also concerning diabetes and Latinos (Rodgers & Thornson, 2001; Fieleke, 2007). The results reveal very pertinent issues surrounding diabetes in Mexico. Above all, the study highlights the need for more health education to encourage prevention, social responsibility, action by the passive, and to remedy erroneous cultural beliefs.

DIABETES IN MORELIA: A CASE STUDY ON THE CULTURAL FRAMING OF DIABETES IN MEXICO

By

Everett L. Long

B.A., Wake Forest University, 2004

A Thesis Submitted to the Graduate Faculty of The University of Georgia in Partial Fulfillment of the Requirements for the Degree

MASTER OF ARTS

ATHENS, GEORGIA

2010

DIABETES IN MORELIA: A CASE STUDY ON THE CULTURAL FRAMING OF DIABETES IN MEXICO

By

Everett L. Long

Major Professor:	Jeffrey K. Springston
Committee:	Vicki Freimuth Patricia Thomas

Electronic Version Approved:
Maureen Grasso
Dean of the Graduate School
The University of Georgia
May 2010

ACKNOWLEDGEMENTS

I would like to acknowledge LACSI and the Tinker Grant Foundation for giving me the wonderful opportunity and funds to travel to conduct this research. I would also like to acknowledge the doctors, professionals, journalists, and citizens of Morelia who trusted me with their stories. Lastly, I would like to acknowledge my thesis committee who encouraged me to make the most out of *my* research.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

Understanding Diabetes

Diabetes mellitus is a disease that now affects more than 220 million people worldwide, and the World Health Organization estimates that by 2030 there will be 366 million cases of diabetes worldwide (WHO, 2009).

Diabetes occurs when the pancreas cannot produce enough insulin or when the body cannot effectively use the insulin it produces. There are two main forms of diabetes: Type 1 in which the individual produces very little or no insulin; and Type 2, in which the individual's body cannot use insulin effectively. The majority of people with diabetes have type 2. There is also a third type of diabetes, gestational diabetes mellitus, which develops during pregnancy but usually disappears after delivery (WHO, 2009).

Though the health complications and consequences are the same for the two predominant types of diabetes, there are differences in causes, treatment and self-care regimens.

Type 1Diabetes

Type 1 diabetes is typically diagnosed during childhood, though in rare cases it surfaces in adults. It usually appears in children whose families have a history of the disease. Genetic endowments from parents along with poorly understood environmental triggers are thought to be the causes of type 1 diabetes (ADA, 2009). Environmental triggers thought to contribute to type 1 diabetes include cold weather, a virus, and diet and breastfeeding habits (ADA, 2009).

However, most people at risk for it do not ever develop the disease, and for those who do, it can take many years to develop (ADA, 2009). Caucasians have the highest rates of type 1 diabetes.

Symptoms of type 1 diabetes include "excessive thirst; constant hunger; excessive urination; weight loss for no reason; rapid, hard breathing; vision changes; drowsiness or exhaustion (WHO, 2009). These symptoms may occur suddenly.

Individuals with type 1 diabetes require daily injections of insulin to survive. Type 1 diabetes is not preventable at this time.

Type 2 Diabetes

The strongest factors for type 2 diabetes are family history, environment, and obesity (ADA, 2009). If a person has a strong family history of diabetes, along with the appropriate environmental conditions, or is obese, then the risk of type 2 diabetes is high. This is particularly true in cultures with high fat, low carbohydrate, and low fiber diets, and there is too little emphasis on physical activity.

Ethnicity is a very important factor in type 2 diabetes. Higher rates of type 2 diabetes have been reported in people of Asian and African origin, and in indigenous peoples of the Americas and Australia (WHO, 2009).

Weight gain and obesity contribute to type 2 diabetes by promoting insulin resistance which means the body incapable of using its own insulin made by the pancreas. Obesity also impedes physical activity, becoming both a cause and a consequence of weight gain, and ultimately contributing to insulin resistance (WHO, 2009).

Symptoms of type 2 diabetes are similar to type 1, but onset is less obvious and more gradual, delaying diagnosis for years in some cases. Because of this insidious course, almost half of all people with type 2 diabetes are not aware that they have this life-threatening condition.

Individuals diagnosed with type 2 diabetes are often able to manage their condition by adjusting their diet and increasing physical activity, though oral drugs are often required to maintain metabolic control (WHO, 2009). Finally, unlike type 1 diabetes, type 2 diabetes can be prevented if measures are taken early on.

The Consequences of Diabetes

In studies conducted worldwide, changes to a healthier diet and increasing exercise have been shown to be far more effective than drugs at preventing diabetes and maintaining metabolic control (WHO, 2009). However, many people are unsuccessful or simply do not incorporate or maintain these lifestyle changes, resulting in severe health consequences that expedite death among millions of people around the world.

Diabetes can damage the heart, blood vessels, eyes, kidneys, and nerves. Specific damages include increasing the risk of heart disease and stroke; reduced blood flow, which contributes to amputations, diabetic retinopathy, which contributes to blindness, kidney failure. People with diabetes have at least double the risk of dying than their peers without diabetes (WHO, 2009).

The global impact of diabetes is tremendous :

- Worldwide, 3.2 million deaths are attributable to diabetes every year.
- One in 20 deaths is attributable to diabetes; 8,700 deaths every day; six deaths every minute.
- At least one in ten deaths among adults between 35 and 64 years old is attributable to diabetes.
- Three-quarters of the deaths among people with diabetes aged under 35 years are due to their condition. (WHO, 2009).

Diabetes costs both developed and developing countries billions of dollars every year. In the U.S. alone, the total cost of diabetes was $174 billion in 2007. This includes $116 billion in

by direct medical costs, and $58 billion in indirect costs, such as disability, work loss, premature mortality (ADA, 2009).

The Case for Mexico and Morelia

Mexico and Diabetes

The population of the United Mexican States was estimated in 2007 at just over 100 million people, and still hovers around that number today. In 2007, diabetes was the leading cause of death among Mexican adults according to the National Death Registry, killing 5,490,000 people of diabetes in the country (Rubí, 2009; Ingleheim, 2007). In an international survey of countries with the highest diabetes prevalence, Mexico occupied the tenth spot on the list with a prevalence of 10.6%. The 2025 projections for Mexico show an increase in prevalence to 12.4%, and an increase in population affected to 10.8 million people, ranking them 6th in the world (International Diabetes Federation, 2007; WHO, 2009) (See Table 1). In 2000, the estimated annual cost of managing and treating diabetes and its complications in Mexico was an estimated $15 billion U.S. (Rubí, 2009).

The Mexican Health Care System

The Mexican health care system is a large organism that consists of three principal subsystems that provide insurance or health care benefits for the more than100 million people of the country. The first consists of a conglomeration of social security institutes that provide health insurance for around 50 million formally employed citizens and their families. Second, there are governmental services through the Ministry of Health that provide services for approximately 48 million people who are self employed or do not have insurance. And then there is a very small private sector that covers less than 2 million people in the country (Lloréns, et. al., 2002).

El Instituto Méxicano de Seguro Social (The Mexican Social Security Institute [IMSS]). Created in 1943, IMSS is by far the largest areas of the social security sector and provides a range of benefits including pensions, health care, disability, childcare, and life insurance. Its health model is similar to that of an health maintenance organization (HMO) that gets funding through the workers who pay into it, along with funding from the federal government. Those who have health insurance through IMSS include any formally employed people (excluding government employees) whose companies pay into it. This would include those who work for businesses, such as department stores, grocers, or car dealerships. Some large organizations, such as some media organizations do not pay into this system and their workers are not qualified for IMSS services.

El Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado- (The Institute for Social Security and Services for State Workers [ISSSTE]). ISSSTE. is another social security group that provides health care to government employees, including state and government officials and teachers. It was created BY a series of laws and constitutional provisions that sought to provide government employees with better health care and insurance. Services and benefits provided by ISSSTE include pensions, mortgage and loan services, funerary services, social and cultural services, and tourism services.

Together IMSS and ISSSTE cover 50% of Mexican citizens of all ages.

La Secretaria de la Salud (The Ministry of Health [SSA]). SSA was established the same year as IMSS, 1943, but did not take its place in the Mexican health care schema until the late 1970s, when economic reform and a large economic crisis caused high unemployment rates. SSA provides health care services to those who do not qualify for social security. This category includes people who do not work for formal organizations, they run a small businesses, or

farmers. SSA provides services for many rural and poorer populations. It is completely funded by state and federal funds and is the cheapest options for health care.

Morelia

Morelia was chosen for this case study because the researcher was already interested in Mexican immigrants in the Athens-Clarke countyand the Northeast GA area. The city was chosen because a census study conducted by the Clarke County Migrant Education Program showed that 33% of the families being served in 2007-2008 were from the state of Michoacán (CCSD, 2008).

Morelia is the capital and largest city in the state of Michoacán, located in west central Mexico. This Mexican state is a little smaller that than the U.S. state of West Virginia, and has a population of 3,985,667 (INEGI, 2010). Morelia has 725,900 residents (INEGI, 2010). It is a colonial city established in 1541, and tourism is the city's largest industry.

Many tourists come to visit one of the country's best examples of gothic architecture, the Morelia cathedral. Another attraction of the city is the aqueduct built in the mid 18th century that runs through the middle of the city and continues for several kilometers northeast. Traditionally, the tourists in Morelia have been Mexican tourists, though this trend is slowly changing as foreign tourists discover what some guide books have called "the best kept secret in Mexico."

Gastronomically, the city is famous for its *dulces morelianos* (Morelian sweets), *gazpachos* (mixed fruit salads with spices), *pastas de nieve* (ice creams), and tamales.

Morelia is like many cities its size, with public transportation systems (all above ground), beautiful parks, gardens, and museums; and a busy city center, with shops, businesses, restaurants, cafes, and bars. There are two main universities in the city, the public *Universidad Michoacána*, and the private *Universidad Vasco de Quiroga*. The city also has several smaller

technical schools, conservatories, and specialty schools that focus on disciplines such as urban development, teaching, and science.

Morelia and Diabetes

In Morelia diabetes and its complications kills more adults over 25 than any other disease. The state ranks 18 out of the 31 Mexican states, in terms of diabetes incidence (Medina, 2008a; 2008b). In 2007, there were 360 new cases of type 1 diabetes and 10,686 new cases of type 2 diabetes identified in the Michocán state health care system (Medina, 2008a). Each year, a similar number of people are diagnosed with diabetes in Michoacán; in this state, as in the entire country, diabetes is the number one cause of amputations, renal failure, and heart disease (Medina, 2008a). Chronic illnesses combined (mostly diabetes and hypertension) are the most costly in the state's healthcare budget, and an estimated 80 million Mexican pesos ($6 million U.S.) is spent on chronic illnesses each year (Medina, 2008b).

Local Health Resources

Morelia, has many public and private hospitals and clinics as well as numerous specialty clinics that advertise their expertise in diabetes. This study involved interviewing patients and doctors at two very different institutions to gain perspective on how diabetes affects their particular patient populations.

El Centro de Educación Y Atención Médica En Diabetes (The Center for Education and Medical Attention in Diabetes [CEYAMED.]) is a private medical institution established in 1985, specializing only in diabetes with an emphasis on education. Dr. Francisco Ortiz and Dr. Guadeloupe Hernández run the center. Ortiz holds a medical degree and is an internist specializing in diabetes. Hernández is a biochemical pharmacist, and also holds a doctorate in investigative biology as well as several master's degrees.

Because it is a private institution, it is considered quite expensive, with the initial visit costing $M500 Mexican Pesos (about $40 U.S.). Subsequent visits cost $M400 Pesos (about $30 U.S.).

The center sets itself apart with its emphasis on education and a holistic approach to the patient. A patient's first visit takes two hours, with one hour with Dr. Ortiz assessing the physical issues, and another with Dr. Hernández to evaluate the psychological and personal issues that affect self care and treatment. Additionally, each patient participates in four classes about diabetes that cost $M100 Pesos each (about $8 U.S.).

The center has a very professional but intimate feel. There are two classrooms with desks, televisions, and books and other educational materials all around. Upstairs are two offices and a medical room. The doctors pride themselves on the personalized experience and attention they provide, and typically only have one patient in the office at a time.

El Centro Urbana de la Salud (The Urban Health Center). This public health clinic falls oat the opposite end of the spectrum from CEYAMED. This is a public clinic operated by the Ministry of Health, founded in 1985, which continues to operate the clinic, this facility serves patients who have no health insurance. The clinic has more than 300 staff, including doctors, nurses, and administrative staff. They treat people of all ages with medical issues both acute and chronic care. In the same waiting room are people with diabetes as well as children waiting to get vaccinated, and others who have a cold or the stomach flu. There was also a women's health section to the clinic.

It is reminiscent of many free clinics in the U.S., but services here are not absolutely free. A medical consult costs between $M10 and $M30 pesos (about $.75 to $2.25 U.S.), a stark

contrast with the private CEYAMED. This price covers most medicines, sometimes there is a co-pay for prescriptions filled at an outside pharmacy.

There are large lines daily inside the busy clinic as people wait to see their appropriate doctors. The clinic is loud, crowded, and doesn't have adequate seating. The typical wait is an hour and the typical consult is fifteen minutes.

Local News Media

The city of Morelia has multiple local and state newspapers, the five largest of which are: *El Cambio de Michoacán* (The Michoacán Change); *La Voz de Michoacán* (The Voice of Michoacán); *El Sol de Morelia* (The Morelia Sun); *La Provincia* (The Province); *and La Jornada* (The Week). Some distribute statewide, but all of these papers are headquartered in Morelia. Journalists who cover the health beat for the first three newspapers were interviewed for this study.

El Cambio de Michoacán is a daily paper that was established in 1992, and is disseminated throughout the entire state. The paper's website states that its readers are mostly comprised of male (53%), married people (67%), and professionally education (37%). The largest age group of readers are between 21 and 30 years old (28%) (El Cambio de Michoacán, 2009). Generally, *El Cambio* is seen as one of the more liberal newspapers of the city, taking a socialist or leftist position on political issues.

La Voz de Michoacán is another daily, statewide paper established in 1948. *La Voz* is perhaps the most widely read and popular of the newspapers available in the city. It is seen as a more neutral newspaper, catering to a wider audience.

El Sol de Morelia belongs to a conglomerate of media outlets established in 1978 that now includes 70 newspapers, 24 radio stations, and a television network (El Sol de Morelia,

2009). Its daily distribution is only in the city of Morelia. *El Sol* is what locals call more of an "*oficialista*" newspaper. This type of newspaper gets much of its information directly from the government, and it takes positions aligned with state and local officials. *La Provincia* is another "*oficialista*" news outlet.

CHAPTER 2

LITERATURE REVIEW

Framing Theory

Robert Entman had good reasons for including the phrase "Fractured Paradigm" in his seminal article on framing theory (Entman, 1993). Over the past 35 years, the theory has come to mean different things to different scholars, and this is evident in how each has "framed" the concept. Early on, psychology and sociology used the theory to understand how people organized and made sense of the world. Today the theory is largely used in communications, where much of the focus is on how media framing impacts human beings. Regardless of the use of framing theory, it imperative to remember that framing is culture-specific. Cultural attributes are fundamental to the theory, because in order for framing to be effective, individuals must share a set of cultural referents upon which to create or understand a frame. This study conceptualizes framing theory by using definitions and constructs put forth by several scholars.

Concept and Definition of Framing

The concept of framing is largely derived from Erving Goffman. In his seminal 1974 book "Frame Analysis," he defines a frame as a "schemata of interpretation through which individuals organize and make sense of information or an occurrence" (21). Goffman writes on framing and how human beings use the concept of framing to organize, classify, and interpret life experiences to derive meaning from them.

Entman puts forth that the application of frames for organization can happen naturally or socially created frameworks. Natural frameworks identify "naturally" occurring events that are

undirected or unguided, such as the universally accepted concept of a single, irreversible time (21). Social frameworks provide a sort of background understanding for events that "incorporate the will, aim, and controlling effort and an intelligence" (22). The flexibility of the social frame makes framing theory invaluable for analyzing health communications campaign.

Robert Entman defines the process of framing as "select[ing] some aspects of a perceived reality and mak[ing] them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation" (Entman, 1993; 52). And though he created the "Fractured Paradigm" concept, Entman believes that framing can be effective because:

> consistently offers a way to describe the power of a communicating text. Analysis of frames illuminates the precise way in which influence over a human consciousness is exerted by the transfer or communication of information from one location—such as a speech, utterance, news report, or novel—to that consciousness (Entman, 1993; 51-52).

Entman's definition begins to more thoroughly shape the concept of a frame and the power of frame creation. His focus on problem definition, causal interpretation, moral evaluation, and treatment recommendation adds to Goffman's concept of a socially constructed frame that can be created and shared by everyone, yet also altered to explain some concept or issue.

Bertram Scheufele's concept of framing amalgamates Goffman's and Entman's definitions. Scheufele considers the several definitions of framing that have been offered and says, "Framing is seen as patterns of interpretation through which people classify information in order to handle it efficiently. Framing emphasizes specific aspects of reality; furthermore specific attributions, evaluations or decisions are assigned to recipients" (2004; 402). Here is the

combination of both cognitive patterns of information organization along with the notion that this organization is affected by the emphasis of certain aspects. Yet he continues on and identifies various levels of framing. He identifies a horizontal level: "1) Journalist or the media system, 2) recipients or society, and 3) political, economical, cultural, etc. actors, groups or organizations" (402). Next, he talks about the vertical levels, or the cognitive or textual levels through which framing can be seen, and includes: "1) as a cognitive complex of related schemata for references, such as events, causes, consequences, 2) in public or inter-media discourse, and 3) as a textual structures of discourse products" (402) (see Figure 1).

The present study will analyze the framing of diabetes at each of the suggested horizontal levels put forth by Scheufele: the first group consisting of journalists who cover the health beat in Morelia; the second (recipients), in the form of patients with diabetes; and finally, of doctors and public health administrators. At the vertical level this thesis will focus only on the first level of cognitive schemata that each group has put forth in the form of in-depth interviews.

Cultural context is of the utmost importance when understanding framing. Baldwin Van Gorp (2007) argues that the effective linkage between framing and an audience can take place only because of the repertoire of frames contained within that culture. If, for example, a public health campaign is trying to use the food pyramid to encourage better eating habits, but that culture does not have that referent, then the message frames are useless. Goffman's seminal work supports this as he opens his second chapter by stating: "[t]aken all together, the primary frameworks of a particular social group constitute a central element of its culture" (Goffman, 1974; 27). Given this, frames will be different depending on the social group, country, language, and all that is included in creating culture. Context and culture are inseparable when conducting frame analysis.

What is a Frame and How does a Frame Work?

The types of frames can be observed in different ways depending on the issue at hand. People use individual frames to understand things from jokes and stories, to negative experiences and vulnerabilities (Goffman, 1974). For example, the way a political joke is understood would vary between generations, as the points of reference would be different. And though these individual frames are built naturally from experiences, they are still flexible and can be influenced by the socially created media frames.

Both news media and public relations play a large part in the creation and pervasiveness of media frames. Subject order, subject choice, and emphasis in a message can alter the entire meaning of the message. In this study, the primary concern is the use of frames in messages and how to use the information gathered in order to create an appropriate health communications campaign.

Looking at the components of a news frame reflects the usefulness of what a frame and how it can be used effectively. This includes Stephen Reese's definition of news frames: "Frames are *organizing principles* that are socially *shared* and *persistent* over time, that work *symbolically* to meaningfully structure the social world (Reese, Gandy, & Grant, 2001; 11). This inclusion of the concepts of organization, shared ideas, and symbols reconnects back to the previous scholars' definition, and once again shows that the cognitively organizing power of a frame is an active process (as Entman) that large groups of individuals use. Van Gorp (2007) considers the "very heart" of a frame is to activate the ideas or schema associated with the given information through a message (65).

When considering the use of frames in message design, such as for a campaign, Kirk Hallahan in his creation of seven models for the use of framing in public relations begins by

saying that "a frame limits or defines the message's meaning by shaping the inferences that individuals make about the message" (207). He goes on to speak about how framing operates by biasing the information that the receiver is presented with by providing contextual clues on the issue at hand, and by providing heuristics that help to guide the thought process (208).

The power of the frame lies in the manipulation of frame effects. The four effects include activation, transformation, formation, and attitudinal effects (Schefele, 2004). Activation effects prompt existing schemata. This could be useful for example, when trying to bring to mind what a diabetic should eat. A diabetic individual most likely already possesses accurate dietary knowledge, however they may just need to be reminded or have the information activated for them. A transformation effect shifts existing schemata. For example, in order to get more family support for a diabetic the frame might begin to shift from the monitoring approach to the integral approach of support. Both emphasize that family should be involved; it simply modifies the *how* they should be involved. The formation effect establishes a totally new frame. This would be needed in an area where the information is simply unknown or completely erroneous. Lastly, the attitudinal effect seeks to switch opinions or attitudes on an issue. This could be helpful in an area like diet and exercise, where the ideas of giving up favorite foods or starting an exercise routine are highly perceived as negative. In this case, the frame would try to present these ideas with more positivity.

Whatever the use of a frame, the function remains basically the same, to highlight pieces of information about an issue and makes those parts more salient. Entman aids us by further defining salience as, "…making a piece of information more noticeable, meaningful, or memorable to audiences" (53). The end in mind of increased salience is to increase the

probability that receivers of the framed information will more easily discern meaning, process it more quickly, and ultimately store it in memory.

One public relations study uses the metaphor of a window:

> The message framer has the choice of what is to be emphasized in the message, as the view through a window is emphasized by where the carpenter frames, or places, the window. If the window had been placed, or framed, on a different wall, the view would be different (Zoch & Molleda, 2006; 281).

Framing Theory and Schema

One of the most consistently important features of framing theory is its connection to schemata. Entman uses the word schemata several times in referring to frames, and Scheufele identifies them as key to the construct of the frame. Some authors put schema and framing practically into the same category (Entman, 1993; Gitlin; 1980), while others insist that they are disparate concepts, and that it is most necessary for them to be separate to properly understand framing as a whole of its parts (Scheufele, 2004, McClelland and Rumehart, 1986). This study on diabetes will follow the Scheufelian model of schema in order to analyze how those individual parts of a frame compose the entire frame.

In the Scheufelian model, cognitive schema refers to "a singular object or relation between objects" (Scheufele, 2004; 404). Schema speeds up the decision process by creating a heuristic relationship between two objects or concepts, by providing "abstract representations of complex events" (Williams, 1994). The components of framing are formed from past experiences that come to be automatically associated with an object (Ruiz, 2001).

This becomes especially important when individuals try to conceptualize the unfamiliar. If the concept of one's reality is based on his or her past experiences, and he or she has no

experience with a particular situation, how does one comprehend it? Part of the answer is by the creation of the cognitive categories many of which are supplied and ordered by a specific culture in the form of schemata (Beamer, 1995).

In general, knowledge consists of schemata that become activated when necessary (Clarke, 1982; 92). Knowledge itself is a complex set of connected ideas, memories, and experiences, or schemata, which make up the basis of cognition associated with a certain piece of information (Scheufele, 2004). These connections, or what Scheufele refers to as a "configuration of schema-knots," are what make up a frame.

Later on, when it is necessary, this activation is made possible by the convergence of media frames and the individual frames in one of three ways. The first occurs by the media's transforming of schema, through repetition, what he calls a step-by-step accumulation until the recipients have adapted the media schema. The second involves completely changing cognitive links by changing relational representations—for example, in cause attributions. An example of cause attribution could be taken from the present health care debate. If a news media outlet reported on the negative aspects of the new health care bill by mostly mentioning President Obama, then people might begin to form the casual attribution that the bill is a failure because of President Obama. The messages may not have directly said that, but still put all of the pieces in one place (frame) to allow the receiver to put it together as such. The final way involves the establishing of new schemata for an object or abstraction (Scheufele, 2004).

Framing and Health

Much of the use of framing with respect to health takes place in the form of creating appropriate messages to influence decision-making behavior. Journalists, health organizations, and pharmaceutical companies are all continually trying to "inform" us on health issues. They

are giving the advantages of some new program or medication, or the drawbacks to eating a certain food, or giving reasons to get a certain vaccination. They are all taking advantage of the attributive property of valence in framing. Valence framing refers to the negative or positive attribute given during issue framing (Scheufele, 2004). The encoding of positive or negative attributes in a message contributes to the perception of the worth of the information (Tversky and Kahneman, 1981). Amos Kahneman and Daniel Tversky (1979) suggested that "the simple positive-versus-negative framing of a decision operates as a *cognitive heuristic* or rule-of-thumb that guides decisions in situations involving uncertainty or risk" (Hallahan, 1999; 208). This positive and negative perspective has much of its roots in prospect theory and has various implications in health-related messages and behaviors, specifically in decision-making, when involving risk goals.

Many of the studies using framing theory as a model for health messages try to convince participants that using suntan lotion is good, or that using condoms is best, or that getting tested for HIV is a necessary risk. These studies employ experiments of negative (loss) and positive (gain) frame messages on intention to perform a certain health-related behavior (Rothman, Salovey, Antone, Keough, & Martin, 1993), how they affect perceived risk (Meyerowitz & Chaiken, 1987), or alter general attitudes on specific health behaviors. Unfortunately, many of the experiments concerning message framing and health behavior have been inconsistent in their manipulations of framing and have lead to contradictory findings (Rothman et al., 1993).

A different application of framing in the health world, and directly related to diabetes, can be seen in Ron Loewe and Joshua Freeman's (2000) analysis of physician versus patient frames in reference to the disease and how this can affect the doctor-patient relationship. They began by stating that "much of the current frustration stems from the different frames or explanatory

models that physicians and patients use to understand the disease" (24). They collected narratives from both sides, in the form of in-depth interviews, and then compared these in order to highlight the differences in frames being used by each side to understand or, in the case of the doctors, to explain diabetes. Their qualitative analysis found vast differences in concerns, treatment regimens, causes of the diseases, and expectations for the future of living with the diabetes. Some of these findings observed quite vast differences in the frames of doctors and those of patients.

Through Loewe and Freeman one can see the efficacy of frame analysis at the individual level, however, its use in public health has also been proved at the societal level. In a content analysis of news frames on tobacco issues and policy from the years 1985-1996 in the U.S., a study found that that tobacco policy followed a shifting of frames by the tobacco control movement (Menashe & Siegel, 1998). In following shifts frames from individual—killing of smokers and non-smokers, and holding the tobacco companies responsible; to a public health problem frame that includes deception of the public and marketing to youth (321). Clearly, this was not done intentionally as frame shifting, but through changes in laws and wording, one can see how framing is one of the essential actors. One of the more important implications in the shift to a public health frame was that the tactic implemented to discourage smoking had also changed. The tactic was no longer to eliminate tobacco and create a smoke-free environment, but instead to discourage smoking by simply stopping the companies from deceiving the public about levels of nicotine and addicting children (321). Also, as the anti-tobacco movement implemented public health frames, the decisions no longer remained in the hands of individuals, but instead within the larger macrosystem of the policy makers. As gradual as it may have been, these new public health frames no longer allowed policy makers to blame the individual for his

or her smoking, but instead caused them to act to protect the public as a whole from a predator-like industry. Given the current state of smoking in the U.S. it is clear that reframing through policy change has been an extremely effective tactic, and in fact the campaign against smoking is considered to be one of the most successful public health campaigns ever carried out in this country (Warner, 1977; Popham, et. al., 1993; Siegel & Biener, 2000)

One may even take a further step back to the societal level to consider the framing of a disease like diabetes itself. Cultures and generations have changed how diseases are looked at depending on the available technology and terminology. For example, recently "restless leg syndrome" has gotten publicity because there is treatment available. No doubt that previously, individuals with this issue simply thought that their legs felt funny at night. Coming from a medical perspective, Charles Rosenberg (1989) mulls over the idea that the world of medicine has in many respects dampened the association with the biological parts of disease to the emotional, cultural, and social phenomenon that can have significant consequences. Every aspect of a disease is socially constructed, "in our culture a disease does not exist as a social phenomena until we agree that it does" (2).

CHAPTER 3

METHODS

Frame Analysis

Consistent with the "fractured paradigm" idea, researchers have used both quantitative and qualitative methods to explore how framing theory can be used to explain and use human communication. Traditionally, much of the research regarding frames uses a content analysis approach (e.g. Menashe & Seigel, 1998), and other researchers have opted for a qualitative approach, such as discourse analysis (e.g. Loewe & Freeman, 2000). Still other researchers question the compatibility of either content or discourse analysis alone in its ability to effectively conduct frame analysis (Van Gorp, 2007). Van Gorp advocates for the combining of quantitative and qualitative methods because of the abstract nature of frames (Van Gorp, 2007). In continuing to advocate for this mélange of methods he says:

> For example, one could start with inductively drawing up an inventory of frames on the basis of media content, public discourse, and a literature review. In this manner, the framing devices that are most indicative of the frames are identified. Subsequently, the researchers determine through deduction to what extent these devices are present in the complete data set. (Van Gorp, 2007; 72)

This concept of combining various types of methodologies to better understand framing analysis provides the structure and categorization of a quantitative process, along with the interpretation and unique in-depth point of view that the qualitative process provides.

Scheufele (2004) in his annotation of types of methods and ways of measuring frames gives us four neat categories as to how the data may actually be collected. According to his review of framing studies, these are: 1) Field studies, 2) Experiments, 3) Exploring recipient cognitions, and 4) using pretests to test schema (418). This study on diabetes in Morelia will use aspects of the first and third types.

The first, field studies, is a combing of content analysis and survey data collection; much like what Van Gorp is referring to. This method is appropriate for the Morelia case study because the data was collected in its proper environment. As was discussed, context and culture is important when conducting frame analysis. Collecting this information in Morelia ensures that the frames are indeed endemic to the people of Morelia.

The third method requires exploring the cognitions, or schemata, of the receivers of the frames through thought listings or interviews, then subsequently using some sort of content or factor analysis (418). Again, this method is quite appropriate for the Morelia study because interviews were conducted that were later analyzed and categorized for recurring themes.

Specifically, when looking at how the media cover public health issues, researchers have used framing theory to both quantify and describe how the media cover particular issues (Fieleke, 2007). The traditional content analysis of news articles can be seen in studies such as that of Menashe and Siegel's 1998 study of tobacco policy and framing. A more descriptive example can been seen in a study on SARS in China that used previously established frames as a way to discuss how SARS was viewed in China versus the U.S. (Luther and Zhou, 2005).

To analyze and interpret the frames that encapsulate diabetes in Mexico, this study, using the city of Morelia as a case study, will combine the qualitative methods of in-depth interviews

and the quantitative methods of categories previously created through content analysis, in order to make recommendations for a health campaign against diabetes in the city.

Case-Study Methods. Using the case study method can be very effective in a study such as this "when 'how' or 'why' questions are being posed, and when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context" (Yin, 1989; 13). Robert Yin goes on to say that the need for a case study many times arises in need to understand some complex social phenomenon, and the case study method "allows an investigation to retain the holistic and meaningful characteristics of real-life events" (Yin, 1989; 14). This case study of Morelia and the very present issue of diabetes seeks to gain more of an understanding of *how* diabetes is framed from the viewpoint of three key players—the news media who report on the disease, health professionals who treat it, and those who suffer from it.

The method of collection will be the interview or in-depth interview, because of its ability to access experiential or subjective realities on an issues (Lindlof, 1995). An in-depth interview is distinguished from other interview styles in that the "answers given continually inform the evolving conversation" (Paget, 1983; 78). Perhaps another appropriate way to refer to these interviews is what Thomas Lindlof calls a "conversation with purpose" (Lindlof, 1995). These purposive conversations will be guided by an interview guide, but will maintain the ability to evolve throughout the course of interaction.

The Interviews

A total of 17 conversations (see Appendix A) were conducted in Morelia, Mexico between July 5, 2007 and August 9, 2007. Each interview was conducted by the researcher in Spanish, audio recorded, and transcribed at later dates. Participants were informed prior to the

interview of their rights as a participant by either having read (in Spanish), or in two cases being read the consent form, and signing to indicate their consent. Each participant was provided with a copy of the consent form in Spanish (see Appendix B).

The first set of interviews included local journalists (represented by J#) who cover the health beat for three separate newspapers: *El Provincia*, *La Voz de Morelia*, and *El Sol de Morelia*. Journalists were identified in one of two ways: either the researcher searched archives of each news paper to find authors who wrote about diabetes and health issues; or the researcher called the newspapers and asked to speak with the journalist who covered the health beat. After contact was established, interviews were set up and held at the newspapers' offices.

The second set of interviews included health professionals (H#). This group consisted of doctors who treat diabetes, and heads of communications from the two largest health organizations in the country (IMSS and La Secretaria de Salud).

The doctors in this category were chosen because of their specialty in diabetes, and the desire of the researcher to investigate both public and private institutions. They were identified through Internet searches and referrals by journalists. One doctor worked in a public health clinic, and the other two ran a private organization. Interviews were held on location for each doctor.

The health communications specialists were chosen because of their association with indubitably the two most important health organizations in Mexico (IMSS and S.S.A.). They were identified through phone calls to each organization. The interview with the specialist of the Ministry of Health was held a local hotel, and the other on-site at the social security office.

The final set, and most difficult to procure, consisted of people with diabetes and/or family members of those with the disease. Participants were identified in one of three ways: by a

doctor, who asked that they take part in the conversation; by intercept, such as in a waiting room; and through referral by acquaintances of the researcher. These interviews took place in a range of places including the city public health clinic (both in offices and the waiting room), the private diabetes clinic, a local hotel, and finally in front of a cathedral where a group of diabetic women held their weekly exercise sessions.

The Interview Guide. For this study, the researcher designed a set of questions much like Loewe and Freeman's (2000) qualitative study on the framing of diabetes by patients and doctors (see Appendix C). And as in their study, the point of the interview was to elicit stories, or in the case of journalists and health professionals, descriptions and concerns, to illuminate aspects of diabetes that each group saw as significant.

The guides first focused on demographic and personal information including: name, race, marital and family status, education-level, and occupation.

The guides for journalists focused on health information production and consumption and social views on diabetes.

The guides for health professionals included questions about health information provided by the organization, health-information-seeking behavior, emphasis in care, observed health beliefs among patients, and observed social support among patients concerning diabetes.

The guides for diabetics and family members of diabetics included questions about health-information-seeking behavior, personal care, health beliefs, and social support.

All guides and consent forms were submitted to the IRB and approved prior to any data collection (IRB # 2009-10924-0).

Implementing Established Frames

As Van Gorp and other researchers have implied, a combination of qualitative and quantitative methods would be a most effective method for the study of frame analysis. To do this, this study will use Van Gorp's example of applying previously identified frames from strategically chosen sets of media texts and literature reviews to categorize and then analyze themes extracted from the interviews. This deductive method of frame analysis allows the research to examine to what extent "certain devices are present in the complete data set" (Van Gorp, 2007; 72).

These frames were identified from studies using traditional content analysis applied specifically to diabetes and Mexicans and Mexican Americans (Fieleke, 2007). Using previously established frames has several advantages. The first is that the data will be categorized according to frames that have been rigorously researched through content analysis and proven to be present and thus relevant in current news frames. Another advantage is that the identified frames are culturally relevant, as they have been specifically tailored for Latinos concerning the issue of diabetes. Lastly, it allows the researcher to extract from the conversations and analyze precisely the frames that are of most concern and are most valuable in creating a proper campaign.

These themes were grouped into two large categories, public health facts and socio-cultural schema, and some have more specific subcategories. The present study incorporated the definitions used in Fieleke's study, but expanded them to include less direct information that can be given in a circumvented way in conversation. For example, the subcategory of disease rates and incidence will not be simply restricted to numbers. It will also include information that makes more general statements or implications on the subcategory (i.e. "There are 100 thousand diabetics in Morelia," as well as, "Mexico has a large obesity problem," will be allowed).

Defining Public Health Facts. Previous researchers have used framing analysis to study various public health issues. In her quantitative study on the cultural framing of diabetes amongst journals that have a large Latino readership in Los Angeles, Fieleke used the developed categories identified by Shelly Rodgers and Ester Thorson in their 2001 study on crime as a public health issue, and applied them to the issue of diabetes (Fieleke, 2007). She extracted three of the categories that were relevant to diabetes in order to constrain her content analysis and labeled them as public health facts (frames); they are perspective, monetary costs, and consequences. Fieleke's study is particularly relevant to the present study because of its focus on Latinos and Latino Americans.

Perspective was important because it helps readers "view and interpret public health issues within a broader social setting" (Rodgers, 2007; 12). The four subcategories of perspectives included: disease rates and incidence of disease, disease disparities, t risk factors and disease prevention.

Disease rates and incidence are derived from an article, or in this case a statement, that discusses a number or otherwise indicates quantity of people affected. Disparities compare rates or facts about diabetes among groups. Risk factors include why and how people get the disease. And prevention refers to information that tells how one can prevent the disease or its worsening, be it through exercise, diet, or proper screening.

Monetary costs are simply statements that speak in terms of economic expenses incurred by the public health problem (Rodgers et al., 2007.) This accounts for all levels, from the individual and the community to state or national costs. There are two subcategories in this section, those that describe the costs of testing or screening and those that describe the cost of receiving treatment (Fieleke, 2007).

Consequences are seen in terms of the outcomes or impact of diabetes "prevention, treatment or screening on local, state, national, and international communities, as well as the psychological and social impact of diabetes on individuals' perceptions, attitudes and behavioral outcomes" (Rodgers, 2007; 7). The three subcategories of this frame are: mortality rates, mortality disparities, and consequences of treatment. The researcher also added the additional subcategory "consequences of improper care," because this was addressed by many interviewees and did not fit into any of the other categories.

Mortality rates give information about the number of deaths due to the disease and information that indicates the disease leading to death. Mortality disparities gave mortality rates and additionally compared groups. Consequences of treatment included information such as the consequences of using or not using diet and exercise to control diabetes.

Defining Socio-cultural Schema. Fieleke continued one step further in her analysis by including socio-cultural schema, or the categories of: social self, lifestyle, religious beliefs, natural therapies, and the interplay of stress and disease (Fieleke, 2007). These schemata came from a conglomeration of studies carried out specifically with the intent to establish more effective and more culturally sensitive ways to approach the issue of diabetes among Latinos (Brown et al., 2002; Coronado et al., 2004; Vincent et al., 2006; Zaldívar & Smolowitz, 1994). She ultimately used these socio-cultural schemata along with the public health frames in order to find out how the news media frame the issue of diabetes for the Latino community in Los Angeles.

Social self was defined as "a person's existence within a family, community, and society" (Fieleke, 2007; 21). In the context of this study, the researcher is interested in how diabetes

affects how a person operates at the family, community, and societal levels. Of particular interest was the social support garnered at each of these levels.

Lifestyle modification was defined as "purposeful changes people make in day-to-day life for medical intervention that allowed them to maintain their cultural heritage and belief system" (Fieleke, 2007; 21). In this section of concern were questions such as, how individuals incorporate (or choose not to incorporate) exercise into a culture where it is not traditionally valued. Or how a diabetic individual might integrate new dietary regimens into a rice, tortilla and meat-centered culture.

Religious beliefs were defined as "the confidence people place in a higher power with respect to their life and their disease" (Fieleke, 2007; 21). Did the patient see his or her diabetes as some act of God? Did he or she look to God for help with diabetes?

Natural therapies were defined as "remedies outside of those medically prescribed such as plant derivatives and herbs" (Fieleke, 2007; 21). Did a diabetic use or make reference to certain plants or rituals to treat or cure him or herself of diabetes?

Interplay of stress and emotion with disease was defined as "patients' strong feeling accompanied by mental and physical change, possibly perceived as the onset of diabetes" Did the patient relate nerves (*nervios*), a frightening incident (*susto*), or some other emotional event to the onset of his or her diabetes?

Additionally, the researcher added an additional category, personal and cultural beliefs, to encompass statements that speak directly to personal ideas, customs, or traditions that can accompany an individual's perception of diabetes.

And while Fieleke used traditional content analysis to identify and count the presence of this information in two newspapers, the present study will build on this approach. The researcher

will extract the necessary information from each interview, looking for key words and phrases, but additionally use the qualitative fullness of the interview to create an even more comprehensive view of the disease in Morelia.

To extract these frames from the interviews the researcher listened to each interview twice along with the transcription of the interview, and identified phrases that included key words that indicated a particular frame or schema. These phrases were extracted out of the transcription and compiled with each of the other phrases that comprised the same frame or schema and analyzed collectively. Each phrase was allowed to be placed in only one category. If the phrase could fall into more than one category, the researcher made the decision as to which category it best fit. These results were then translated into English (see Appendix D).

The present study, however, did not rely solely on the quantity of information collected, but also included the rich and telling qualitative aspects of the interviews. This allowed for the importance of what was actually said and occurrences such as pauses and tone and inflection of voice to be considered in the analysis as well. Rather, this study adopted the concept that repetition *and* emphasis both highlight importance. If a frame is so common among various groups, there must be some inherent use of that frame in developing an effective program against diabetes in the city of Morelia. This leads us to our research question:

RESEARCH QUESTION: What aspects of public health frames and socio-cultural schema would be most effective in designing a public health campaign against diabetes in the city of Morelia?

CHAPTER 4

RESULTS

A total of 17 interviews were conducted (see Table 1), and 16 will be used to conduct the frame analysis. The interviews consisted of conversations that lasted from 10 to 45 minutes with three local journalists; six health professionals; seven people with diabetes and/or family members; and one nutrition class. One interview with the Internist and Director of Loans of IMSS, Dr. Hector Manuel Estrella Quintero, will be omitted. At the end of the 30-minute interview he recanted on his decision to sign the consent form, citing the need for more express permission from the Mexican government to participate in such a formal and possibly publishable university study. Also, the recording of a nutrition class held at the city health center will be omitted because the content was covered in an individual interview with teacher, Dr. Marquez, and also because of audio problems. Transcriptions of these two interviews are not included in the appendixes.

Table 1. Interviewee Demographics

ID	Name	Sex	Age	Marital Status	Children	Education	Occupation	Diabetic?
J1	Humberto Castillo Mercado	M	43	S	0	B.A. in Journalism	Journalist	N
J2	Astrid Del Ángel	F	23	S	0	B.S. in Communications	Journalist	N
J3	Arcelia Lara Medina	F	24	S	0	B.S. in Communications	Journalist	N
H1	Franciso Rodriguez Ortiz	M	U	U	U	M.D.	Internist	N
H2	Guadelupe Partida Hernández	F	56	M	U	Ph.D.	Biomedical Pharmacist	N
H3	Francisco Marquez	M	86	U	U	M.D.	Internist	Y
H4	Javier Coria	M	U	U	U	B.A.	Director of Communications	N
H5	Aranza Zucayón Nieto	F	36	U	0	M.P.H.	Manager of Social Communications	N
P1	Carmina Martinez González	F	48	M	7	6th grade	Fitness Instructor	Y
P2	Autor González	M	57	M	4	High School	Contractor for Phone co.	Y
P3	Celia Ortiz	F	U	M	4	Unknown	None	N
P4	Alicia León López	F	U	M	at least 1	U(Illiterate)	None	Y
P5	Gloira López	F	U	U	U	Unknown	Unknown	Y
P6	Ana Figueroa	F	75	Widow	0	6th Grade	None	Y
P7	Sergio Flores Mendoza	M	27	U	0	B.A. in	Culinary Chef	Y

Public Health Facts (see Table 2)

Perspective. There were 60 total statements that included information about perspective on diabetes. When looking at the four subcategories, *prevention* was mentioned by far the most times with 36 mentions. Between the three groups health professionals mentioned prevention the

most times (16), with both patients and journalists mentioning prevention a total of 10 times each.

Risk factors was next with 12 mentions. Patients mentioned risk factors the most (6), then health professionals (4), followed by journalists (2).

Disease rates and incidence follows, with seven mentions. Health professionals spoke most in this category (5), followed by journalists (2), and no patients had any mentions of rates or incidence.

Finally, *disparities* was mentioned the least at six times. Again Health professionals talk about disparities the most (3), followed by journalists (2), and once again zero patients discussed disparities.

Monetary Costs. There were 15 total mentions of *costs* in the interviews. None of the interviewees spoke on the cost of testing or screening. In cost of treatment subcategory, health professionals mentioned *costs* the most (8), followed by journalists (6), and finally, patients (1).

Consequences. The subcategory, *consequences of improper care* was mentioned the most (6). Patients talked on the consequences of improper care the most (6), followed by health professionals (1), and zero mentions from the journalists. *Consequences of treatment* followed occurring four times in conversations. However, the reverse appeared in the consequences of treatment category with health professionals mentioning this the most (3), followed by patients (1), and still zero mentions from journalists. The subcategory of mortality rates had 2 mentions, both from journalists. There were zero mentions in the mortality disparities section.

Socio-Cultural Schema (see Table 3)

Social-Self. Twenty-one references to *social-self* were made. Health professionals made the most (11), followed by patients (6), then journalists (4).

Lifestyle Modification. Lifestyle modification was talked about a lot in the conversations (19). Patients spoke the most on the topic (11), followed by health professionals (7), and then journalists (1).

Religious Beliefs. Zero mentions of *religious beliefs* in connection to diabetes were made in any of the interviews.

Natural Therapies. Five total mentions of *natural therapies* appeared in the interviews. Journalists had the most mentions (2), followed by health professionals (2), and the patients (1).

Stress and Emotion. Stress and emotion had a total of 11 mentions. They large majority came from health professionals (6) and patients (6). One mention of *stress and emotion* came from journalists.

Personal and Cultural Beliefs. Personal and cultural beliefs were mentioned a total of 13 times throughout the interviews. Health professionals mentioned these the most (8), followed by journalists (4), and lastly, patients (1).

Table 2. Public Health Facts

Category	*Subcat.*	*# of occurrences*	*Journalist*	*Health Professionals*	*Patient*
Perspective					
	Disease Rates/ Incidences	7	2	5	0
	Disparities	5	2	3	0
	Risk Factors	12	2	4	6
	Prevention	36	10	16	10
Total		**60**	**16**	**29**	**15**
Monetary Cost					
	Cost of Testing/ Screening	0	0	0	0
	Cost of Treatment	15	6	8	1
Total		**15**	**6**	**8**	**1**
Consequences					
	Mortality Rates	2	2	0	0
	Mortality Disparity	0	0	0	0
	Consequences of Improper care	6	1	1	4
	Consequences of Treatment	4	0	3	1
Total		**12**	**3**	**4**	**4**

Table 3. Socio-cultural Schema

Category	*# of occurrences*	*Journalist*	*Health Professionals*	*Patient*
Social Self	21	4	11	6
Total	**21**			
Lifestyle Modification	19	1	7	11
Total	**19**			
Religious Belief	0	0	0	0
Total	**0**			
Natural Therapies	5	2	2	1
Total	**5**			
Stress/Emotion	14	1	6	8
Total	**14**			
Personal/Cultural Beliefs	13	4	8	1
Total	**13**			

CHAPTER 5

DISCUSSION

Public Health Facts

Perspective

Disease Rates/Incidence

Health professionals were mostly likely to mention diabetes rates and incidence (5). The survey instrument did not prompt respondents on the subject. The researcher asked no questions about disease rates or incidents. Health professionals and journalists concern themselves daily with prevention information, which could be a reason that they were so much more likely bring up these advisements. But, what about the citizens of Morelia? Are they not absorbing the fact that diabetes has such intense effects of diabetes on the city? Or are they simply not provided with the proper guidance?

J3: There [IMMS] they have a list of 56,000 diabetics in Michoacán. That's just in the social security. One would have to add the ones from the Ministry of Health and one would have to add the ones that go to private hospitals.

Journalists and health professionals are acutely aware of the amounts of people affected devastating affect of diabetes on the local population and health care system. These are extremely important numbers for local public health because they don't have the money or the space to meet the needs of all diabetic patients.

In referencing state statistics, another professional looked at the bigger picture, which indicated that the disease must be attacked from higher up.

H3: Here in Michoacán there are about one hundred thousand diabetics. But if I put together the Micoacanos that there are in the U.S., there are more there. There are about 7.5 million [total Michoacanos in the U.S.], here there are about 4[million] total.

This statement addresses how the problem of diabetes continues even outside the borders of the country, and strains both the U.S. and Mexico.

The lack of mentions by patients in the disease rates category shows that patients have little or no frames in reference to the intense effects of diabetes in the city. This lack of reference points the need for health communicators to create and make accessible more frames that stress the importance of the high prevalence and incidence of diabetes in the city. People cannot act on a information that they do not possess or do not feel is important.

Disparities

The *disparities* category follows the same pattern as the disease rates and incidence category—it was talked about only by health professionals and journalists, and not at all by patients.

Most of the talk of disparities centered on the well-known fact that Latinos are more likely to develop diabetes than some other races.

J2: And it [diabetes] is also a genetic problem for Hispanics.

H3: I see here in Michoacán…as we are Latino Americans we have a higher proclivity to diabetes.

However, the more interesting information about disparities was not based on race, but instead on age or early development of obesity, a major risk factor for diabetes.

J3: Here in Michoacán we have a severe obesity problem among children. I think that the secretary of health commented to me that we occupy fourth place in the number of children with diabetes, at the national level. Fourth place nationally.

H4: Because you know, here in Mexico we are in first place in childhood obesity in the world. And for adults we are in second place. Only the United States beat us.

There are some obesity studies that put the U.S. and Mexico at first and second, respectively (OECD, 2005). And though indexes for the obesity levels of children are not readily available, the gravity of this disparity is disheartening on both sides of the border, as we realize that these two countries are generating more overweight and obese children who will be more

likely than past generations to become diabetic, continuing the entire chain of health repercussions that accompany it

Once again this is another category that suggests that because there are no mentions by the patients, that they have little or no frames to reference the disparities of diabetes. Frames that emphasize Morelia's and Mexico's diabetes prevalence versus another country's could be extremely useful in providing a concrete comparison. For example, a frame highlighting Morelia's childhood obesity issues in comparison to that of a similar town in Brazil could be more make citizens more easily recognized as a problem. This type of frame could prompt concern and perhaps some to action.

Risk Factors

Risk factors were equally likely to be mentioned by health professionals (4) and patients (5). Health professionals were more acutely aware of the risk factors for diabetes, and to the researcher's relief it appears that the patients interviewed were aware as well. When patients were asked the question "what caused your diabetes?" most responded quickly with information about their obesity, genetic factors, and the fact that they had very poor eating habits. This raises the themes that most emphatically presented themselves in the *risk factors* category: recognition of risk factors and obesity.

Recognition of risk factors. Again, when patients were asked to respond to questions about the origins or causes of their diabetes most patients referred to actual biological or genetic causes of the disease.

P1
Int: What caused your diabetes?
C: Well, probably obesity. Surely obesity. Well, there are many factors. My obesity, you know I got married at 15, I had a baby, and I got fat. From that point on it started. But if one doesn't know anything…What does one do when they don't know that [lifestyle] is what causes this [diabetes]? And my family, my family, including my mother has all ended up with diabetes.

P2:
Int: So, what causes diabetes?
A: Bad food above all. And heredity. My parents were diabetics, so I inherited it.

P4
Int: And what caused your diabetes?
Ana (patient): [pause] I weighed 110 kilos [242lbs]…
Dr. Marquez: Obesity.
A: I say that's what it was.
M: Yes, that was it.
A: I weighed 110 kilos.
M: And are your mother and father diabetic?
A: No.
M: No one else? Diabetic siblings?
A: No. I only have a sister, and she doesn't have it.

Each of these patients mentioned obesity, diet, and/or genetics. Patient P1 immediately referred to her previous obesity, though with a bit of hesitation. She started off by saying "probably obesity," then abruptly corrected herself by adding, "surely obesity," later adding that of course there were multiple factors. In that correction the nonchalance of her former traditional thinking quickly gave way to her relatively newfound understanding of the disease. Patient P1 has been diabetic for over 14 years and is now a fitness instructor for diabetics, but still she takes a moment to switch from saying that her former obesity had "probably" contributed to her becoming diabetic, to saying obesity that had absolutely contributed to it. It is important that she and other diabetics recognize and understand the risk factors for this disease. It is relevant in that they need to better understand the disease in order to take the proper actions. And if they truly understand then they may serve as resources for others with the same risk factors.

Patient P4 exhibited similar behavior. The hesitation in her voice could be heard when she answered. There was a noticeable pause before she spoke, but when Dr. Marquez confirmed, she was assured when he questioned her about her genetic disposition and it turns out there was none.

The notion of passive attitudes toward health begins to appear in the risk category. Journalists, health professionals, and patients alike all recognized that people in Morelia may be aware of the risk factors, however, many times they just do not always act upon them.

J3: Overall, because I know that if some of my relatives have diabetes, surely I'm going to have it. And you know it is hereditary. The hereditary factor is the principal [reason] that diabetes appears. Yes, I think that people are interested, but when they have an example of someone who has been affected and their kidneys don't work, etc.

H1: Some people think yes, by having the genes there is risk, and few take any action. They take their glucose levels periodically, watch their weight. But the majority don't pay attention to this, and they develop diabetes.

P1
Int: So did you know about diabetes before? Did you know that you were susceptible?
C: Not until I started to come here. Yes, a little before, I began to see my mother get sick. And the ignorance. Sometimes there are so many errors, we committed so many errors out of ignorance.

P2: But before if someone tells you, "don't get fat because you're going to get diabetes", right then you don't feel it.

. The doctor said that they might even go as far to get their glucose measured periodically or try to watch their weight. But, as the journalist pointed out, in the end the risk only truly becomes relevant when someone close gets sick with something serious, such as kidney failure.

Patient P1 answered that she did not know she was susceptible to diabetes, and then changed her answer to say that her mother's illness was a personal wake-up call. She then admitted that ignorance of these risk factors was the root of much of her family's error.

Finally, P2's statement once again showed how people in Morelia might ignore advice, even though someone readily offers it to them.

So, a different question becomes, if the patients already possess the frames, how does one get them to act upon that information?

Obesity. The word "obesity" arose many times throughout the interviews. Admittedly, it is hard to talk about diabetes without mentioning the "*O*" word. It was mentioned several times by participants.

J3: Becoming obese equals diabetes, period.

H3: The people of Michoacán, the only part of the pig that they don't eat is the hooves. We eat the intestines and this is bad for you, to eat the intestines, eat the fat of the pig. But we don't want to eat a better cut of pork, lean meat, without fat. Nor eat white meat: chicken, fish, turkey, beef, and if you don't want this, well eat cottage cheese.

H4: The biggest problem of obesity in Michoacán, he [the director] can describe it to you, is centered in the indigenous communities. Where the food is corn based—posole, tortilla, tamales, tacos, tostadas, all of this is made of corn.

Here they began to acknowledge much of the root cause of obesity and diabetes in Morelia—food. Health professionals listed foods that Mexicans not only eat on a regular basis, but also (and what is very obvious when being there) in which they over indulge. Later on, health professional H3 got very aggravated talking about taco or hamburger stands on every corner, asking me had I yet noticed. The answer was clearly "yes." We can see from H3's statements that it is not that eating certain foods, like pork, is bad, it is that people are eating too much of the wrong parts. And though journalist J3 and many of the patients interviewed knew that "obesity equals diabetes," clearly not all act on this knowledge.

Patient's recognition of these risks demonstrates that they have developed the proper frames in respect to risk factors-bad eating habits, obesity, etc. The larger issue is that these frames are not always easily accessed, and that cues must be given to prompt the knowledge contained in these frames. Half of the battle is already won in this category; the frames have already been properly established. The other half of the battle lies in cueing to action. In some cases, there needs to be quicker activation of these frames for personal reference and to inform others. In other cases the cue to action needs to be triggered altogether.

Prevention

Informants in all categories indicated that prevention is one of the most important components in any discussion of diabetes and Morelia. Prevention was mentioned 36 times, the most of any other subject of conversation (social-self is next with 21). Prevention was the highest recurring theme in discussions with health professionals and journalists, and among patients was the second highest recurring topic (lifestyle modification was first). It is logical that health

professionals would mention prevention the most, but it quickly became clear that, as much as eluding diabetes altogether was desired, is not achieved in most cases. Or as one doctor said in his interview:

H1: Well, medicine should be to prevent, in all cases. Unfortunately that's not what we do.

The recurrence the issue of prevention and the way participants discussed it highlighted the need of more concentrated efforts in this area of diabetes treatment.

Lack of Prevention, Education, Passive Attitudes. The deficiency of prevention was a major theme discussed among health professionals and journalists. Most attributed this to the absence of health education. The need for education is urgent at the at the city and state levels, as well as at the community and family levels, where many times health education is simply not addressed.

Two heath professionals from the private institution CEYAMED discussed the overall lack of health education, making it even harder for patients to avoid the onset of diabetes because they cannot act upon what they do not know. And it also makes it more difficult for education-based institutions such as CEYAMED provide effective preventative information without having the treat already progressing diabetes.

H1: Again, as there isn't health education, people don't achieve prevention. Let's say, five percent of the people at CEYAMED achieve prevention, and the other ninety-five percent arrive because they already have complications. Unfortunately.

H2: In spite of the fact the center is a center of attention [for diabetes], and with the end in mind of prevention, the last five years we have more dedicated to the diagnosis aspects of diabetes. Although we give talks about what diabetes is, preventative measures, and things around that. But particularly, people arrive here already with some symptom.

Int: And who would you say is responsible for these prevention programs?
H2: Well, I think in the educational programs, where one supposes that there are in the schools.

It then becomes a vicious cycle: little or no education on the disease is provided, people know little or else ignore what they do know, so they come to medical attention with full blown diabetes. A this point, they must proceed directly to managing the disease and its complications.—or as one doctor implies, they are simply forestalling death.

H4: What happens is that you see more people, diabetics, preventing a fatal ending. Fewer are the diabetics that are controlling their diabetes through diet and exercise.

Patients recognized too that Morelianos are notorious for being passive when it comes to health and do not always take the proper steps, even when they are already sick.

P3: Few pay attention to that. Few people have the knowledge. Many times they say, and this is not knowing, many times they say, "I have to lose weight, I already quit bread." But then eat a lot of meat, a lot of junk and not getting any vegetables. Then if someone tells you to lose weight, if they don't give you the knowledge, you don't lose weight. This is what has happened to us.

P2: Yes, what happens is, how do I say, while you aren't sick it isn't important to you. When you are sick that is when you want to prevent and when you want to exercise and stop eating.

P3: And many people don't listen. We have children that don't listen. They don't listen. We are watching them and [say] "look child, prevent this so that the same thing doesn't happen". Then they turn around and it's happened, the same. Then there is a moment in which they listen and when we realize that we are already inside the disease.

P2:
Int: Well, there should be more focus on prevention.
A: Yes, because in many places, for example on the TV, they give it to you superficially. If you want to take it, you take it. But if you aren't sick, you don't take it. You take it when you are already sick. When you have to start paying attention so that you don't have complications ahead. But before, if someone tells you not to get fat because you're going to get diabetes, you don't feel it. And you've already have now to care for yourself. Then when things change, we stop.

Interviewed together, this husband and wife (only the husband has diabetes), illustrated how little attention people pay to preventative advice. They refer to themselves when the wife (P3) talked about people advising them to lose weight and stop eating certain foods, but did not listen, and continued on with their regular habits.

Like people elsewhere, Morelianos wait until serious symptoms occur before they go to a doctor. The husband (P2) talked about people not being motivated to change their lifestyles until it is too late. The couple's talk is evidence of late development of these prevention frames, but prove that health professionals can be effective in generating these frames and getting patients to act on them. The fact that they try to pass this crucial information onto their children shows the necessity of these frames to be built into a culture, so that they become recognized as relevant frames. However, if this is the classic case of what goes on in the average Morelian household,

then this combination of inadequate frames in the household and school combined, with highly genetic predispositions predict a bad future for Morelia with respect to diabetes.

Specific preventative measures. Another theme that permeated discussions of prevention was the need for specific about diet, exercise, and medications.

H2: If we don't begin to tell them what is happening, this is what's going on with the pancreas, or not only is it going on with the pancreas, but it harms other organs, etc. Perhaps, we begin by saying, starting to care for yourself you have to follow the medical indications, that you have to continue living, that you can't just hide under the covers and say, "I have diabetes and I don't want to go out."

H3: We give them education so that they don't get to the point of complications.

H3: Beans no, they are legumes. Legumes like beans and lentils in moderation. So, if you don't have meat, eat beans. But please vegetables during the day, green leafy ones. Spinach. What others do you know?

H3: And then you will know how to end this diet. I have this guide. Copy this, and make it smaller, then have them laminate it for you.

H3: You have to eat two that are this size. Take your coffee or your oatmeal. And eat two tortillas, this size. Or if not you eat one normal size wheat roll. You fry two egg whites and you eat that with the tortillas. And you can have some orange juice.

H3: And we review well with them how to train for exercise. And exercise has a meaning. During exercise muscles burn and absorb things without the necessity of insulin. So the patient saves insulin. And additionally it diminishes the resistance to insulin.

Doctors in the city are desperately trying to provide the information and the foreground to help their patients do their best to prevent the worsening of their conditions. From the very specific information about how each organ acts and reacts to diabetes, to the diet and exercise routines, these doctors are providing many tools to expand knowledge and life expectancy among diabetics. Watching and listening to these two doctors in particular showed that they care very much for their patients and are very passionate about what they do.

Dr. Marquez (H3) took an enormous part of his supposed 15-minute visit with his patient (P4) to point out particular food groups and portions, so that the patient had a well-defined concept of what she should be eating. He asked her repeatedly about her eating habits and knowledge of what proper eating is. His efforts are the beginning of what eventually leads up to one of the best efforts that the Urban Health Center provides—the weekly breakfast club.

The breakfast club is a class held once a week at the clinic to give diabetics the chance to experience first-hand what a healthy and balanced meal its. The center provides of the meal, and while they are eating Dr. Marquez gives them vital information about a balanced diet and quizzes them on what they have learned in previous visits. Conversations with the patients revealed that they at least knew the imperativeness of a healthy diet.

P1: Because Mondays and Wednesdays I'm at the "5th of February" Group, which is the health center group. Tuesdays, Thursdays, and Fridays I'm at Health Child. And back at the health center Tuesdays, Thursdays and Saturdays. Tuesdays and Thursdays I'm here from 10-11, then I leave really quickly. And that's how I go on. What do you think? If I go home I do my chores. But I've felt really good.

P2
Int: And what information did you get in the end? What important things do you remember?
A: Careful eating. Eating and the medicines that we should use more or less. Yes, that was the most important.

P2
Int: And for you, what is the most important about diabetes: exercise, the medicine?
A: Well, right now exercise is the most important.
Int: And where do you go now for exercise?
A: The exercise we do now is very light. I just do walks. Just walking…
Int: Every day?
A: Yes, I try to do it every day.

P7:
Int: What is it that worries you the most about diabetes?
S: What worries me the most? Well, the reality is that I don't worry, since I'm very strict about what I need to do. I don't worry.

P7: By nutrition and sport that I started doing. Then you simply begin to know you body more. How you are during the day and what dosage [of insulin] you need.

Here is the difference between a patient who is beginning to embrace the need for more exercise and a healthier diet (P2), and two who have mastered the lifestyle. It was very evident when talking to P2 that he did not really care for the newly implemented exercise or diet, but that he very much understood the necessity of following through with them. When asked if he exercises every day, his answer included the word "try," indicating that it has not become fully integrated and his life, and is still seen as a task.

On the other end of the spectrum however, P1 and P7 have fully adapted and moreover enjoy the exercise and a healthier lifestyle. This can be seen by P1's dedication to her classes,

which became her profession a few years after she was diagnosed with diabetes. She runs three exercise classes for diabetics at various locations in the city. The feeling of accomplishment and control over her struggle was evident in her voice and in the huge smile on her face as she reflected on her past, and marveled at her present achievements.

The excerpt from the conversation with P7 illustrates how successful self-care can eliminate the anxiety of being sick. His reward for being so regular with regard to diet and exercising is that he has become more in tune with his body, and almost no longer has to worry about the complications of diabetes.

These patients have different, yet valid frames about diet and exercise in the world of diabetes. They are at different stages in the disease and this can affect how a frame shifts. The task of health professionals becomes to find ways to populate communication frames with feelings of satisfaction and accomplishment to a healthy diet and exercise, and avoid frames that highlight feelings of limitation and restrictions.

Prevention as the answer. The good news is that health professionals and journalists very much perceive education as imperative. Herein lies the hope that since health care professionals and news media understand the importance of prevention, and are willing to work to increase preventative measures that slowly but surely, prevention could have its proper affect. This can be seen in responses to questions like, "what do you think the most important aspect of diabetes is to present in an article?" Or, "what could be done better with respect to diabetes in Morelia?"

J1: But I think that the most important thing is to know the disease. What brings it on, how to prevent it. I'm sure that the most important is measures of prevention.

J1: I think that designing programs, political, publics with constant diffusion through informative media. In schools, for example. I think there lacks basic health education, let's say in primary and secondary school. Health education. And the kids from primary school should be taking about this, no? Because it's a public health problem. It's very grave in Michoacán. And the parents don't do it. So this corresponds also to the Ministry of Education. These themes should be included in textbooks. Yes, they do it, but it's in a very superficial way. And so that when you're an adult you'll be more conscientious. Because we don't exercise or we do very little. We have to begin to do

something in the schools, and also stop permitting junk food. Precisely for the same reason. And we have to inform them.

J2: Well, it's all in prevention. In the little ones, in children if we begin to teach them that natural things are better, that one shouldn't eat so much sugar.

H4: But the best would be prevention. And one gives prevention at a young age, or as young adults. How? Physical activation and a healthy diet. Nothing else. Because I feel personally that the government of the republic should work in two area a lot stronger, one, in the educational sector. From children…And two, a more coinciding between the mediums of communication, in a strong way. Investing in the media and communications for prevention action. With respect to prevention, I assure you that the institutions are…very diminished. Because those who have rights to the services crowd the consults and crowd the hospitals. And you have very little time for a culture of prevention. So those are the two fundamental pillars. Overall, education.

H5: In October we celebrate Senior Citizen Week. That is a week where we celebrate federal health. Where, of course, the diagnosing diabetes is intensified.

H5: In all of our health fairs, even if it's not about diabetes, there is a detection of diabetes, and weight and height. This is one of the components we put in all health fairs, even if it's about something else. And it's one way to bring knowledge about this disease closer to the people.

And though they all agreed that prevention is the preferred method and most important in the fight against this disease, they also realized that it is not always easy to implement.

J3: Yes, the statistics, like in all of journalism. But specifically in health pieces. It's important that they here that there is a certain amount of cases of diabetes, or that the number of diabetes increase so many people. But in spite of the fact that the first few paragraphs reports the amount of cases this year, in the following paragraphs of the article I put it in context and always try to reiterate that diet, exercise, not eating junk food, even though I seem like a broken record. They get mad that I write that. Or sometimes they shorten the article, but I always try to put it in some context where I say that this, this, and this are important.

H2: It has been very hard to communicate with the state health authorities. Because it isn't necessarily the experts who attend, but their associates, and sadly the information isn't diffused, and I don't know if it's a good diffusion of prevention [information].

More support for prevention is needed from as far up as the state and federal levels. Even those in charge of the news media could be more supportive of their writers who see the importance of discussing prevention, though it may seem like a "broken record."

The resounding answer seen here, and proven over and over again through research is that the power to fight diabetes ultimately lies in prevention. And this must take place in the form of early and thorough diabetes education on proper diet and exercise for patients; more responsibility on the parts of the governmental and public health institutions; and more effective use of media communications to diffuse this much needed advice.

Monetary Costs

As with many countries and health care, cost is an extremely important issue to every player on the issue of diabetes. Diabetes cost nations billions of dollars a year in health care, and Morelia is no exception.

J3: The subject of diabetes is extremely important because according to the Ministry of health, that continuously reports that it is the disease that represents the highest cost for public health.

J3: The Mexican Institute of Social Security is the institution that has the largest quantity of patients, I think that 80% or a little less than 80% of the budget goes to taking care of chronic degenerative diseases like diabetes. Diabetes heads up along with arterial hypertension. That speaks to us about a true public health problem.

Diabetes continues to be an issue for the state and federal governments in what is probably considered the worst way after direct effects—monetarily. Eighty percent of the budget at IMSS, the largest health care provider in the country, goes to chronic degenerative diseases, with diabetes and hypertension at the forefront. This reporter made no mistake when she said, that this is a "true public health problem."

It is certainly important that the effects of cost be disseminated; sometimes it takes precedence over lifestyle messages that could be more effective. Each of the three reporters when asked about what issues of diabetes were important to their editors had the same response—statistics. Impressive and gory statistics do bring diabetes to the front, but many times go on to lack the information that those who will end up partaking of that 80% actually need.

J3: Once, the health journalists won the front page because the director was very interested in what had occurred to me to ask the IMMS delegate. I asked him, "Dr. how much the this institution spend on treating chronic degenerative illnesses?" And he told me that, "80% of our budget." And I asked him how was that possible? Is it true? He replied that it was, 80%. And that's how we won the front page: IMMS SPENDS 80% OF IT'S BUDGET ON CHRONIC DENGERATIVE DISEASES."

Though she was very proud that she had gotten a health story on the front page, she had also previously said that when she tried to incorporate more substantial information, "[t]hey get mad that I write that. Or sometimes they shorten the article, but I always try to put it in some context where I say that this, this, and this are important." She admitted that this hunger for

statistics is similar throughout journalism, but knew that people would benefit more if the mind-blowing statistics were balanced with practical advice for consumers.

Cost as a barrier. And even though the health care system is pouring money into diseases like diabetes, many people still cannot afford treatment. Cost proved a barrier for those who went to the cheaper public institutions as well as those who attended private ones.

J2: Well that is another situation. Because in Mexico the social security isn't free for everyone. I think that this is another reason that people don't treat themselves. It's expensive.

H2: When they feel bad. And not only when they feel bad, when they have economic resources. One of the biggest limitations for us is that. If you say to a patient that you have to come every month, and we make concessions to give packages, where we write you in for twelve sessions and we charge for tend. But in the end the person doesn't go. With the statement, "I couldn't come doctor because I couldn't pay for the consult."

H5: I think that something that also influences a lot to a large part of the population here is economic resources. And access to medicine is hard. And when the health institutions are lacking people have to buy it. And when they have to buy them, if they have to buy them, many times they don't have money.

H5: I can tell you that one year ago one of the difficulties that the Ministry of Health had was having was economic resources to buy medicines. So, even if you give them the best medical knowledge that you have, if you don't have medicine and they can't get it, well it doesn't go anywhere. And it's not the fault of the ministry, nor the fault of the people, but instead the consequences of this country.

P2/P3:
[Wife to husband]
C: Well at least I bring him, because he didn't want to, [looks at husband] right?
A: Well, I don't have time.
C: Sometimes, we don't have money.

In this collection of statements we are reminded that not everyone has social security coverage , which makes it difficult to obtain medical attention, even at a discount. The exchange between the husband and wife at the private institution brought to mind the popular English saying, "if only I had the time and money." The full transcript shows that the husband does not have the time to attend the clinic because he is always working, but if he cuts back on work he won't have the money to pay for the services.

Lastly, health professional H5 noted that some times the organizations lack the resources to provide care. Giving us the perspective of the organization, this health communicator admitted that there are times when the Ministry of Health cannot provide the necessary medications. And

all of the "cues to action" in the world do not make a difference if there are not materials available to follow up.

When looking at cost, cue to action was referenced by another health professional.

H1: Many of this corresponds to the state. Then, the government, sometimes, begins with their radio spots about diabetes prevention, the complications, and the same for obesity. And in this way they can reach out a little more to the people. Here we were doing it for a while, but it's expensive. Definitely, the one with the money is the government…We note that when the companies begin with these spots the flow of patients increase.

This doctor's observation that an increase in radio spots about diabetes makes for a noticeable influx of patients to his office, suggests that the disease is not typically on the airwaves.. Unfortunately, he also said that ads are too expensive for an institution like his to run continuously, though not for lack of trying. The government sponsors diabetes messages about once or twice, otherwise these spots are used for political campaigning.

H1: For example, we just had elections, and they said that they bombarded us with I think, 38 million spots. If those 38 million spots were put toward health that would be stupendous.

The cost frame is significant for all respondents; however vary a bit among the groups. Journalists and health professionals have a firm grasp on how the monetary cost of the disease affects the overall picture and patients tend to focus on their individual needs. The more individual frame held by the patients does not seemed to be an effective frame in motivating them to act. Patients are thinking in terms of the cost of the next visit, not the price of medications for the next 35 years. In the case of the patients the cost frame needs to be expanded to include a more extensive views.

Consequences

Three subcategories were originally going to be used for the *consequences* section of the Public Health Fact Frame. A fourth, *consequences of improper care,* was added because it came up so often in interviews.

Consequences of improper care

Patients frequently mentioned the consequences of improper care. Because the worst consequences of diabetes such as numbness of limbs, kidney problems, and blurry vision can manifest themselves quite rapidly they are at the forefront of the minds of the patients. These responses were mostly elicited through questions about what worried them the most about the disease or what the worse things that could happen to people with diabetes. Naturally, they worried about their personal futures and what the disease could mean for their health.

P2/P3:
INT: And what worries you the most about the disease?
A: Well, that I won't take care of myself and that it will advance faster and more terribly.
C: And that we can't control it. For example, right now we don't understand it well, right? We change medicine and we don't understand why

P7:
INT: And what are the worst things that can happen to people with this disease?
S: The worst things. You can lose extremities, do damage to other organs, like your kidneys.

P7:
INT: And what frustrates you about it?
S: I get frustrated a lot because like I told you, I've always taken care of myself. I've done exercise. And I say "why did this happen to me? Why me?" It was just simply a moment of thinking like that. But, if diabetes still affects someone who is taking care of him or herself, what do those who aren't taking care of themselves suffer?

The first patient (P3), a 57-year-old man, along with his wife, both worried about the consequences of losing control. Throughout the conversation a high level of anxiety showed on their faces as they expressed their inability to fully commit to exercise and to embrace the new dietary patterns. It was clear that they both knew what the terrible consequences of diabetes could be, and wanted to avoid them at all costs. But they also said that they did not always understand or agree with the methods of control. Ultimately, they comply with the medical advice to avoid these consequences, despite that they don't always understand why.

The second patient (P7), a 27-year-old man with type 1 diabetes, came from almost the exact opposite position as the 57-year-old, but knew that the consequences could be the same for him and that he must continue with his strict regimen. His frustration was derived from the fact

that he has always taken care of his body, but through circumstances out of his control has diabetes. His last question is very much rhetorical as he juxtaposed on his innate passion to care for himself and his body against those who do not share that same passion and may face the terrible consequences he has just mentioned.

Patients' possession of frames that accentuate the worst possible scenarios with diabetes can extremely useful for a campaign. If a patient has a high level of perceived threat, and a message can access that frame, then it has a higher chance of cueing an individual to action.

Consequences of Treatment

Quite oppositely of the last subcategory, health professionals spoke the most on the consequences of treatment.

H2: There are those who come to our registration table to say, "I want to see if I can take my glycemic index before, because I the insulin shot makes me panic". And you see that and you think, well if you had tried the insulin, I assure you that you would've had a better physical condition and a better life.

H3: But here we give them a healthy eating habits. That is to say a balanced diet. We have our five fundamental nutrients, sugar, or carbohydrates, protein, fats, minerals, and vitamins. And we add a bit of fiber. Then, they eat the appropriate amount in relation to their weight, or their body mass index. Then they begin exercise and begin to control diabetes.

H3: What happens is that some are capable with the glycemic control package, to control the cholesterol and the other factors. And many respond well. We are operating at about 65% efficiency.

P1: Because every Monday and Wednesday I am at the "February 5th" group, that is the group at the health center. Module 8, of the health center. Tuesdays, Thursdays, and Fridays at the Child of health. And here at the health center I come Tuesdays, Thursdays, and Saturdays. And that's how I get on. What do you think? I get home and go on with my chores. But I've felt very good.

A great sign is that much of the talk was focused on diet and exercise as opposed to medication. The health professionals and the patient alike were focused on diet and exercise to produce positive repercussions of treatment. Even when Dr. Marquez (H3) was interviewing the patient (See appendix A) he encapsulated the conversation about the medications she was taking with questions, advice, and suggestions about eating properly. He did not dwell on the medications part of the visit, but instead made it the shortest part of their conversation. This very

positive occurrence ensures that the patient is not overconfident or uniquely reliant on the medication, but instead knows that it is a compilation of efforts, much of which is derived from lifestyle choices.

Socio-Cultural Schema

Social-Self

Social-self was the most talked about concept in the socio-cultural schema section. Responses related to socio-cultural schema were elicited by questions about the possible stigmatization of diabetes, whether the disease is perceived as an individual or public health issue, and how family members are implicated. Related information was often volunteered during the conversations with no prompt.

Stigmatization of the disease, but not the people. The researcher asked every journalist and most of the health professionals whether people with diabetes are stigmatized. Most answered "no."

J3: I don't think so. I think that diabetics suffer the least discrimination. I think that since it is a chronic degenerative disease that doesn't reflect itself in a physical aspect, at least until you have renal insufficiency, there you can see it some. Many people live with diabetes. But since that are controlling it with medicine no one realizes that they have diabetes. Then there are other specialists that say that diabetes causes depression. They say, "I'm diabetic, am I going to die? There is no cure, I'm going to die in 10 years." But here in Michoacán there is less discrimination than people with HIV.

H1: No, no, no, there isn't discrimination against patients with diabetes. Many hide their disease. Because, well, that's part of the denial. And some stay that way all of their lives, in denial. But the majority accept their diabetes. And if they have good control of their diet, exercise and medication, as they say, it doesn't even seem like they have diabetes. But it depends on the level of acceptance of the disease.

These two answers reflected the common idea reiterated by other interviewees that since the disease is slow to manifest physically and can be virtually invisible if maintained properly, that there is less stigma and overall, less worry about the disease. No one wants a stigma against people with diabetes to exist, but it is important to note the significant blasé feeling about the

disease. No doubt this feeling has much to do with its ubiquity throughout the city and the country.

H5: I think that since it is already such a frequent problem, it's just something else that there is in life. Like, "yes, well my grandmother is diabetic, well, my mother is diabetic, my father," and so on. Perhaps, it's just something that they see as something that just happens in life. It's what happens to a lot of people and it's not abnormal. And that is why they don't usually give it too much importance.

P7: It's not hard. But since it is a disease that doesn't bother you much, you feel normal. But it's easy to start neglecting. To start eating whatever.

The health communications specialist (H5) here talked about just that, how the frequency of diabetes in the population makes it just another normal occurrence, and consequently not given much importance. The citizens of Morelia watch their parents, siblings, and friends develop diabetes, deal with the consequences, and do not see this as an out-of-the-normal experience. This "overnormalization" of the disease contributes to the insistence of diabetes. People do not have much fear about developing the disease because on the whole it is seen as manageable.

The patient (P7) here even said that he did not consider living with diabetes to be hard. Conversely, he also admitted that this also makes it easier to start on the path of letting oneself slip back into bad habits. If living with diabetes does not even seem like a nuisance to those who have it, then one can deduce that for those who are do not have diabetes or are unaware, that the disease is not taken with the proper gravity.

When looking at how people thought of the disease itself, diabetes does have a reputation as being a silent killer.

J2: Yes, it is stigmatized. Because diabetes is bad and it's a disease that kills you. And not always. Well when you have diabetes at its maximum, yes. But before no, before that you can treat it.

P7: That they should take care of themselves because it's a silent disease. So one has to continuously check.

So, people in the city are aware of what diabetes is capable, however they just do not attach the proper importance to it. This journalist (J2) talked about his family members in a rural

community on the outskirts of Morelia. He implied that though his aunt had known that she had diabetes she simply did not act on it.

J1: And close to there lives my aunt, another aunt, about 50 years old that works. She's a single mother, a widow. And she knows she has the disease.

Producing frames that contain healthy levels of perceived threat could coax more people to take preventative measures rather than reactionary ones. A frame that highlighted the threat of diabetes as a "silent killer" may prompt more people to go get tested. Though, reversing these endemically lackadaisical frames about the severity of diabetes would take much time and much effort.

Family involvement. When considering the role that family and relatives play in the lives of those who have diabetes, one finds quite a bit more positivity.

H1: If anything is changing it is that. I have been managing diabetes since 1976, at the National hospital of Mexico, and later I came here. At that time much of the responsibility was basically put on the patient. Now, all of that is changing. The responsibility is shared. And one has to look for family support. You can't just leave the patient alone. And it's very common, for example, that everyone else is eating unhealthy food, and the patient has his or her vegetables, no, no. All of that has to change. The same eating habits that the patient takes on and the exercise, the family has to do as well. And also, the other thing is that we look for is that the family doesn't become the police, you know? Because later on they will say, "don't eat this." No, no, no. The patient has his or her responsibility. And they [family] are going to help prepare the healthy meal, and do the best they can with their diabetes. But, we can't let them become the police. Because that is far from helping, and so not to generate conflict.

H2: There are some who come to talk to you, to tell you a lot of things that aren't about the disease. "All of this is happening to me outside of my family, and I don't know how to resolve it". And so we organize talks to talk with the family, especially heredity and treatment of the patient, acceptance by the family, and to avoid the signaling that in the family there is a person with diabetes and that we all must revolve around him. So our talks are sort of the same thing that happens with alcoholics. We are not going to revolve around him.

P4:
INT: No, your family.
A: Ah, yes.
INT: Or eating right.
A: Yes, my daughter. I say, "let's go eat", and she says, "no mama, that's bad for you. You eat this." And sometimes she has a Coke and says to me, "don't drink any."

P6:
INT: And how do you help your sister?
F: I bring her her medicine and to the doctor when she needs. But she doesn't like this doctor at all. I liked the doctor we had because he understood us. And now we've got this clown.

P7:
INT: With respect to your family, how do they help you with this disease?

P7: Yes, they help me a lot with the food stuff. They try to also consume the products that I can consume. I don't know if…well, more than anything else, they help with this.

The first doctor (H1) was confident that he had seen much improvement in how families have been involved with a diabetic family member in the past decades. He acknowledged that family support, especially with respect to diet and exercise, is crucial in how a diabetic takes care of him or herself. He also disapproved of what he referred to as the "policing" method, or the family simply monitoring what the diabetic family member does and scolding him or her for any transgressions. He insists that this creates tension, and definitely does not promote an atmosphere of self-sufficiency and support. There is much hope to be seen in the fact that he is continually transmitting this attitude to his patients and their family members.

The second doctor (H2), who works out of the same office as H1, echoed this view, but went further in her comparison of the diabetic to an alcoholic. She holds family talks to educate everyone in the home about the disease, treatment, and the important concept of acceptance. She felt that it was important that the family not simply revolve around the diabetic family member, but to create the best support system possible by integrating as much of the healthy diabetic lifestyle as possible into the entire family unit.

From two of the patients interviewed one gets an idea of how this actually plays out. Patient P4 responded that her daughter helped her by monitoring her diet. This is the classic case of policing which H1 disapproved of, though there is still merit in the effort. Eventually this effort carries through by way of aiding the patient stick to her diet.

Patient P7 also defers to food when asked how his family helps him, though he has the ideal situation, in which his family actively tries to consume what he consumes—the integration approach.

When asked how she helped her diabetic sister P6 has more of a utilitarian answer. Her answer is full of negativities about the doctor (Dr. Marquez), with whom she disagreed on the way he approaches diabetes treatment—heavy on the diet and exercise. Before the interview she was observed in the breakfast club clearly rejecting the dietary information Dr. Marquez had to offer, and also refused to try any of the health food provided. She stated that she was only in the class to get the information for her diabetic sister who could not attend because she could not climb the stairs due to her condition. So, though she supports her sister financially, there is much doubt as to whether she is supporting her in more essential ways.

Mexico is a traditionally very family-oriented nation, and this could be one of the best resources that the country has in its fight against diabetes. Also, as the generations become more informed this may be even more effective, as a pattern can be seen from the interviews. Patient P7, aged 27, enjoys thorough and genuine support from his family. Patient P4, late 40s gets support as well, but in a more traditional policing style. While patient P6, aged 75, simply provides the utilitarian support that her sister needs, rejecting much of instrumental lifestyle assistance that may be most effective.

It was encouraging to see that health professionals, journalists, and patients all had positive schema associated with the family's involvement with a diabetic member. These active affirmative schemata provide the perfect grounds to cultivate frames that will involve the family in beneficial and integral ways. Also, upon activating these already related feelings of togetherness a frame can help to create a healthier family unit.

Diabetes as a public health issue. The responses to the question aimed at diabetes' place as an individual issue or societal issue bodes well as all responses indicated that it is at least *becoming* more of a public health issue, if it is not already considered as such by most.

J2: I think that right now you see it more as the individual. Yes, I think that it is beginning to be a bit more in the social conscience that it is a disease of society. More because what I said about obesity. It's becoming something that is part of society. But right now it's "HE has diabetes."

H1: Today diabetes is not considered an individual problem, but instead a public health problem.

H5:
INT: And one more thing. Do you thing with respect to the Ministry of Health that they approach diabetes as more of an individual thing, or more a societal problem? More a public health problem or of each one?
A: I think both ways. Well, from the point of view of public health programs etc. I think that in the ministry of health there is a large consciousness that this is a serious problem.

P7: It seems to me that it's becoming more of society. From the same example of the soft drinks. They are making soft drinks with Splenda. Things like that, so it's becoming more of society. Before I imagine it was more of the individual. One saw how you couldn't eat this, or because of a craving or encouragement, I eat it anyway. But now in society they have sugar-free chocolate, bread too, everything. And before there wasn't. So, it's becoming more of society.

Journalists and health professionals alike used the phrase "public health problem" in reference to diabetes without being prompted by the researcher. One journalist pointed out that because there is so much public spending on the disease that it is inevitably a public health problem, a very true statement. The first doctor (H1), when responding to the question immediately said that it is a public health issue, not an individual problem, and his earlier reference to how he had definitely seen changes through the years with respect to how family had become more involved, suggested realization that the problem should be approached more at the community and societal levels.

There were also some mixed responses on the public health aspect of the disease. Journalist J2's initial response was that it is seen more as an individual problem, but reconsidered and acknowledged that since obesity had become such an public and publicized issue, that it has also brought diabetes more into the societal light. She thought that the transition was still happening, but that most times it was individual.

The health communicator at the Ministry of Health (H4), felt like it was approached both ways—with public health organizations working at the societal level and doctors treating individuals as such.

Finally, the last patient reflected on what he had seen recently, and also felt that the transition was underway due to the wider availability of products that are better for diabetics to consume. As a diabetic he felt like the widespread availability and use of products like Splenda made diabetes more current for those who do not have the disease, by recognizing that there are individuals who need these products.

The positive social schema related to diabetes is another encouraging point and key area that would be useful for a campaign to recognize. Frames built on the schema of collective responsibility could encourage people to support those they know with diabetes more or bring it into awareness for those who do not. In health campaigns awareness is often a goal that must achieved to create any sort of action.

Empowering diabetics. Another common theme, that also supports the thesis that diabetes is becoming more widely recognized as a public health issue in Morelia, was some of the empowering activities and efforts carried out by some organizations. Both private and public organizations in the city are currently exploring various ways to recognize the importance of diabetes in this city. Moreover, much of the efforts are done to recognize those who have done well to maintain and improve their lifestyles despite the disease. This takes place on an individual level as well as the community level.

H2: The success we have is through a decalogue that we have. It begins by saying, "my person," and ends with the family in general. And end by saying that with respect for others as well as myself. And when one begins to deny it, with which of these points are you not complying? Because here it says that I am making myself responsible, so decide and do it. Because the way or the belief that we are offering you is a function of your family, a function of others that have the same suffering and a function of society.

H3: We could have the medal of victory given by the Joslin clinic. But we can't afford it, and so we look for other ways to give them a prize and recognize their efforts. And some are very smart, very capable. Some. And they follow their exercise to the letter. And they do it daily, as they should

H5: another thing that we do regularly is every November 14, I think that is world diabetes day, the self-help group celebrates with an event in which we invite people from other regions and they help. There is usually a march on Main street. And later some cultural event with dances, and a food tasting of what they cook in their classes. A tasting of food healthy for diabetics.

Frames built on schema of empowerment could help tremendously with the way both diabetics and non-diabetics see the disease and themselves, and how it might affect their health and that of others. At the individual level, it serves as a reminder that one does not have to succumb to the treachery of the disease, but has the option to maintain one's health and integrity through acceptance and compliance, and that there is reward in this. At the interpersonal level this empowering allows a diabetic to communicate their concerns and victories to those who matter the most to them—making for a better support system. And at the community level it allows diabetics around the city to come together with those who understand them the most, other diabetics, and celebrate the possibilities and overcoming the challenges.

Lifestyle Modification

Patients talked the most about lifestyle modification in both negative and positive ways. The changes that must be made in order to live successfully and healthily with diabetes are not always welcomed as can be heard from some patient interviews. Most times these modifications are initiated upon discovering that one is diabetic, not before, in which case if that is at a later stage in life making these changes can be extremely difficult.

The health professionals' mentions of lifestyle modifications return to the absolute imperativeness of education. It is as important in trying to maintain health as a diabetic as it is when considering prevention.

Patient acceptance of modifications with some difficulties. When talking about diabetes and lifestyle modifications the main topics are diet and exercise. Doctors push it, the patients know it (even if they do not comply), and even the journalists try to write about the importance of diet and exercise with respect to diabetes.

The interviews showed that patients understood that they must alter how they live, but this comes with the difficulties of practicality and comprehension. The changes are not simply difficult to implement because they are crucial tasks, but many times the individuals did not understand why these life adjustments are necessary. Other times they commented that they had just been so stuck in their way of life that they can really not see another way to live.

H1: The basic problem here, more with type 2 diabetes, is changing of one's lifestyle. They are people that have had a minimum of 30 to 40 years with a lifestyle of bad habits and sedentary. That is what takes a bit of work. That is why we insist on diabetes education. Because if we educate them, we will give them treatment so that they can make themselves well.

P3: Something that we didn't do before, exercise. And the exercise is basic. And it's hard for us to understand it, because we don't want to do it.

P2/P3
INT: And what frustrates you about the disease?
A: It limits me. It limits me from what I am accustomed to. And more than anything it limits my food. So many years of eating bad, but flavorful eating. Now it's very different.
C: Sometimes we still fight because of that.

P3:
C: But since "could've" doesn't exist, from here and now on we have to understand the truth. Except the quantities that they gave us in the diet are so small. Aren't they?
O: You are accustomed to eating in excess. Yes. So do you still want that, or no?
A: Not any more. Almost never now.
C: Almost never. We fight less.

P4:
INT: And how difficult did it seem to you to care for yourself with diabetes?
A: It's just that I was used to eating everything. And coke is a craving.
INT: And that's the most difficult thing?
A: Well, for me it's that.
INT: And have you come to change your diet?
A: Later on it's that if one begins to neglect that you have a little sip, then you go down.
M: None of that.
A: No, not even a sip.

The doctor (H1) explained why it takes so much effort for these modifications to become second nature—years of bad habits, and a sedentary lifestyle, sometimes for as many as 30 or 40 years before the problem is recognized. So making this sudden change becomes an ordeal for individuals with much practice at eating poorly and watching television instead of going for a

walk. If one factors other issues, such as jobs and children, then it is little wonder as to why many of them do not make the corrections .

Patients P2 and P3 readily admitted that they took no exercise before they found out that the husband was diabetic. The wife talked about how she now knew that exercise was a basic need for a diabetic and everyone, but confessed that they still did not really understand why, and furthermore did not really want to do it. The husband blatantly expressed his nostalgia for the "flavorful" foods he ate before.

The fourth patient expressed the same feelings when answering about the difficulties of diabetes—that she used to eat whatever she wanted, but is now limited. She confessed her cravings for Coca-cola, but knew that with even one sip, she could begin on a backward path to bad health.

The schema related to lifestyle changes are mostly negative for the patients. They know that these lifestyles are necessary to maintain, and accept that, but with a bit of sadness and longing for the foods or beverages they miss. Frames built to encourage these lifestyle changes will have to abandon the negative aspects. Much readjusting and frame creation will have to be done to expel the negative schema

Education and maintenance. Education was recurring aspect; not only in helping diabetics to begin treating themselves, but also to aid them maintain this new and foreign lifestyle.

H1: Education is the key. If there isn't education, there isn't total adherence. This is what we are reinforcing at each consult—education. Besides that we have courses that we give about how to live with diabetes.

H1: The course is done in four sessions, one each week. The first is the general aspects of diabetes, what the causes are, how the symptoms are. Then the following module is diet, the third is exercise, and the fourth complications and treating diabetes. Basically, information about surviving.

H2: That is the reason why we dedicate ourselves to therapy, focusing first on diet and exercise. And later, pharmacological questions.

H3: Then we teach them how to eat, we teach them how to change. We watch them, we control their metabolic index. And generally, it goes well.

Health professionals here truly understood the importance of combining education with treatment regimens. Reinforcement adherence becomes weaker without education. And as was seen in the previous section, patients did not always know why they were altering their lives. Here the doctor answers the questions of why they do not always comply—absence of education. It is logical that people would not continue to perform an action simply because someone instructed them to. But through educating these individuals they gain insight and understanding along with other tools to aid in their new lifestyles. H1 went on to talk about the courses they take, ending on the idea that the clinic provides information about surviving with. A simply metaphor applies here: if one has a survival kit but no instructions on how to use it, the chances of survival are truly diminished. He is providing both the kit and the instructions.

The second doctor (H2) hinted at the importance of focusing on diet and exercise *first*, then going onto the pharmacological issues. It is encouraging to see that these doctors are not simply trying to get as many patients as possible, stuff them with medicine, and go on to the next. By putting diet and exercise first, she is giving the patient a hierarchy of importance in their new lifestyle. This will be so important in self-maintenance.

Doctor H3 from the public health clinic reiterates the same message. His choice of wording here is crucial, "we teach them how to change," he said, instead of saying, "we change them." This implied that he is not preaching at his patients, but instead working with them to provide them with the information that they need to make the necessary modifications themselves. This is extremely important in self-efficacy and the maintenance of health in diabetes. Although this institution does not have the time and resources that the private clinic

has, it recognizes and emphasizes the importance of not just providing medicine, but providing the educational tools that last their patients a lifetime.

The fact that so many of the health professionals have education schema when concerned with maintenance is a good sign that they are trying to provide answers and explanations as opposed to a quick fix. Their commitment to education shown in these interviews bodes well for their patients and the city. They understood that it is not simply about the short-term fix, but instead the long-term self-maintenance that can only be achieved with the proper education.

Religious Beliefs

Interestingly, there were no mentions of religious beliefs in any of the interviews. This is surprising because Mexico is traditionally a very Catholic nation. Today it is still considered a Catholic nation, though obviously to a lesser extent today.

Perhaps though, much of what at one time might have been attributed to religious beliefs is now mainly spoken about in a fatalistic manner. This is discussed in the *Personal and Cultural Beliefs* section.

Natural Therapies

Natural therapies, or alternative medicine, have also traditionally been a large part of the Mexican culture (Coronado, Thompson, Tejeda & Godina, 2004). There were not many mentions of this type of medicine occurred in the interviews, though the schema that accompanied the idea of using it was mostly negative. Natural therapies was brought up each time without prompting from the researcher who would subsequently ask the interviewee to expound upon the conversation about these natural therapies.

Still present in Mexican culture. Though few mentions were made, the ones collected indicated that natural therapies are still a large part of the Mexican culture with respect to health

and diabetes. Two journalists both used phrasing that indicated that these concoctions of "who-knows-what" maintain their popularity in trying to treat the disease.

J2: And you know what many Morelianos have? Household remedies. Tea of I-don't-know-what. That, to lower your sugar a cactus smoothie in the morning. So there are a lot of myths. And, yes, we have a lot, in general Mexicans, also Morelianos, we are faithful to our remedies. In that we are really natural. But after your little water, you have a coke. Then it doesn't serve much purpose.

J3: This is largely important, and you have to write it a thousand times. Because diabetic people, more in the interior of the state believe that with herbs, that with who-knows-what, a branch of whatever...And here in Michoacán there is a large culture of traditional medicine, which is what we call it. And they believe that that cures diabetes.

The second journalist (J3) indicated that it is more present in the more rural areas of the state, but that it is definitely still present and in some cases people believe that these remedies have curative powers. And though these remedies may not be harmful they certainly do not cure diabetes.

One doctor said that he does not prohibit these remedies as long as patients follow the medical advice that he gives.

H1: The others [myths] are more about alternative medicine. What we advise is that it's not prohibited, but never to abandon medical treatment. And all of the options that alternative medicine has are welcomed.

In fact, he said that they are welcomed. No doubt he has more of a chance of success with his patients if he integrates their belief in natural therapy with proper medical treatment, then if he simply rejected these ideas as erroneous and antiquated.

One patient in talking about a treatment used by her mother implied just that, that these actions were erroneous and antiquated.

P1: Because my mother, at the beginning, "there's so much to do, there's so much to do." Water, and water with lemon, with some lines of salt to quench your thirst.

She spoke regretfully about their ignorance about the disease and then grateful that she had been properly educated.

The schemata that accompany the issue of natural therapies are ones that acknowledge its existence in the Mexican culture, but that mainly discourage using their absolute curative

powers. The interviewees implied that the schema held by many people about these therapies could be damaging in treating diabetes. These frames that include ideas that these remedies are cure-alls will keep legitimate medical information outside of those frames rendering it ineffective.

Stress and Emotion

Mainly patients (8) and health professionals (6) talked about stress and emotion. Originally this category sought to explore some of the traditional Mexican associations of fear (*susto*) or anxiety (*nervios*) to the onset of diabetes, however, the researcher expanded the category to also include mentions of the other emotions that can accompany diabetes.

Susto, nervios, coraje. One mention of these ideas was during the interview with the health communicator from Spain (H5), who speculated on how the people of Morelia viewed the disease mentioned what she had heard.

> H5: I've heard a lot that people attribute their getting diabetes to *sustos*, or dislikes. I'm not sure if there is any reason that justifies it from a physiological point of view that can link to it. Or if simply you don't realize. I don't know.

She has the unique position of living in Morelia and being able to see it as an outsider because she is from Spain—two very different cultures though they share a language. Her reflection on the idea of *susto* reveals her unfamiliarity with the subject, which shows how this idea is endemic to Latin America, if not simply Mexico.

There was one patient (P6) who attributed her sister's diabetes to not one, but all of these ideas.

> P6: Well, when I got married…we'd be together for hours, and my husband died, and she told me to come live with her and her husband. And they fought and they fought with me. And I owned my things, and they wanted me to sell my stuff. And the children…they would throw the keys to open the doors, they would go in before her. And they would throw her out. And later I would arrive and knock on the door. [INADUDIBLE] And I throw them out. I threw them right out. So then the flew to the door and the girl [the sister] was walking and they grabbed her and started beating her up like a dog. And she felt bad. And from that point on she's had diabetes. It's those animals' fault… And that's why she has diabetes. It's not from being sick, it's from nerves. It's from nerves the diabetes that she has. That's why she's neither happy nor unhappy. Because the diabetes that she has isn't from being sick. It's a conflict that she has in her body. Because of that. From "susto" [(fright)] and from "coraje" [(anger)].

This is the classic Mexican case of diabetes being brought on by a situation, a feeling, an emotion, or combination of them all. This 75-year-old woman insisted in the beginning of the interview that it was not traditional diabetes, but instead "diabetes of the nerves," and that the doctors were not treating her sister properly. She is the same woman who was very vocal about her dislike for Dr. Marquez and his "methods" (proper diet and exercise). This woman is an example of how these ideas can affect how effective a patient's treatment regimen is by diminishing the acceptance of treatment. Her associations of fear and anger causing her sister's diabetes, inhibits her from understanding the information that Dr. Marquez is trying to provide. Like this patient, others who associate these schema with diabetes may be more likely to reject proper treatment, which ultimately would lead to faster complications and a faster death.

Fear. Fear, specifically fear of death, was talked about as an emotional weight for diabetics. As with any other serious disease, many patients, upon being diagnosed with diabetes wonder about the worst-case scenarios and their futures.

H2: It's undeniable that the first few interviews people come with fear, it's one more thing that I am responsible for through the education. When the finish with the doctor they come with me. And I begin to question them about their life plans in a year. Five. Ten. And there is when the fears begin to come out. But yes, it is true that there is a much more marked fear for death.

H2: It depends. For example, if it's a child they as me: "am I going to be like this all of my life?" "Am I going to be able to play sports?" Each one has his or her own questioning. Children focus on the future. They are not thinking about getting leg cut off. They say: "and will I be like the others? When they are older they say: "Can I get married?" "Can I have children?" And when they have evolved to a more advance diabetes: "What about the complications?" Then each one has a question to ask. And there is something else that is important: in men, they begin to worry about their sexual potency.

H2: And then when people know the diagnosis and you realize that you are going to die from it, the fear comes from the first instance of diagnosis, and there isn't really a real-time acceptance. It takes them months to accept what they have.

J2. Then, you have to scare them a bit. Because if not, they don't understand. If you don't say that you can die, which is true, they don't get it, they don't pay us any attention.

This doctor's (H2) primary job at the private institution is focused on the individual and maintaining mental as well as physical well-being with respect to diabetes. She talked a lot about

the fear that pervades the initial sessions, especially with reference to the future. When she asks her patients to think about various points in time, this future becomes complicated by their newfound knowledge that they are diabetic, and the anxiety and fear set in.

She commented that she has become very in tune with the questions and fears that arise depending on the stage of life and age of the patient. And though each fear is different, they are all very real and valid: children worry about their normalcy with regards to their classmates; young adults think about how this will affect starting a family; men worry about their sexual potency. All of these very real fears can be calmed through informing these individuals about their new lives.

Lastly, one journalist gave a different perspective on fear—using fear as a motivator to action. She stated that the urgency of this disease has to be transmitted, even if through a scare tactic, otherwise people do not listen.

Depression. Depression can be one of the unexpected side effects that accompanies diabetes. This depression can occur as an actual symptom of the disease itself and other times a depression can emerge from being diagnosed with the disease.

H2: One of the things that we review is the stages of depression. There we have a job when it's depression. If there is an inclination toward depression then it is important to detect it—the doctor that does the therapy consult. You are going to fall into the same depression, that you see at the psychotherapist. Fear and denial accompanies getting closer to death.

P1: I found out because I felt ill, and now I know what I didn't know then, that it was called depression. An anxiety. I couldn't sleep, in other words, I felt very bad, a lot of stress. But I didn't know what it was called. Then I went to the doctor.

P1: But when, I remember that I was in bad place. I cried, cried, and cried and the doctor said, "go ahead and cry, cry until you can't cry any more". But I rested. And after that, I haven't cried any more. I'm clam. Yes, there are times that I let go a bit, because it's a disease that sometimes does that, and in a later…[hand gesture that indicates she is fine]

P1: Here in Morelia there are a lot of diabetics. And it makes me sad, it makes me sad, but I pay attention because I've been there. Sometimes when I have a doctor's visit and I see people leave crying, desperate. Why? Because they've been informed that they have that disease. And sometimes I talk to them if I have the opportunity to approach them. "Take it easy, it's a disease that can be control, and we can live many years with it, if we know how to control it."

This patient (P1) gave very concrete examples of depression throughout the stages of diabetes. She talked about her bouts of depression from before she was diagnosed, while she was dealing with her diagnosis, and her triumph over that depression, in which case she can now help others. She admitted that she was not even aware that a condition called "depression" existed, and was even less aware that it could be brought on by diabetes. Surely there are others in the city are suffering these same feeling of restlessness and anxiety, and probably do not consider that it could be because of diabetes.

The patient went on to talk about an early visit with Dr. Marquez, in which she just fell apart and cried and cried; and he encouraged her have this cathartic moment. Now she is under control and has mostly good days. She admitted that there are days when some sadness appears, but indicated that they are few. An encouraging part is that now that she has her diabetes under control, she can educate others through her experiences in their place. She talked about how she instantly recognizes the grief that can overtake someone when they are diagnosed with diabetes. Her recognition and subsequent interaction with these people could serve as a pivotal moment for these individuals.

Stress. Some patients interviewed used the word "stress," but with others the stress was evident. There are the very tangible stresses of living with diabetes, such as the daily routine, lifestyle modifications, costly medications, etc. And then there unexpected ones that come along the way.

P3:
A: Yes, exactly. But I'm going to give you an example. There are places that we go to and there's nothing to eat. We arrive at some towns and there's nothing to eat. So what do we do?
O: And there is a solution there, and it's to wait.
A: For example, I go to Lazaro Cardenas, but from Lazaro I go to a country ranch and work for five days. It's a distance of 100km. Then what? There are no [healthy] places to be found!

This interview took place with the patient while his doctor was present. When the patient began asking the doctor just exactly how he could make sure that every eating situation was a

healthy one, especially since he travels for work, he got very frustrated. First, the doctor told him to wait until he got home, but that is obviously not possible. Later, the doctor advises him to bring some of his own food. But the patient became upset because these answers do not help his situation. There is no doubt that this stress follows him daily on his jobs as he travels—thinking about what he will eat next hoping that there will be a healthy choice available, all while trying to resist temptation. This environmental aspect of diet in Mexico is out of his control, yet somehow he has to find a way to control it. That lack of control creates stress.

The various emotional schema associated with diabetes is underestimated by diabetics themselves, which no doubt means that for others it is non-existent. The fear, depression, and threat could serve to construct threat type frames that appeal to the emotional side of individuals. Universally, no one wants to be sad, scared, or frustrated and these types of frames could spur some to take action.

Personal and Cultural Beliefs

This section was added because throughout the interviews many people continually mentioned what notions or ideas Mexicans, and more specifically Morelianos, held regarding diabetes. These beliefs would be extremely important to consider in creating a campaign in the city.

Fatalismo. Fatalism is a notorious characteristic of Mexicans when it comes to health issues, and applies to diabetes as well (Rodriguez, 2007). This belief of "what will happen will happen," contributes to many facets of the worsening of the problem of diabetes in Mexican society. Some choose not to go to the doctor at all and never find out, some find out and choose not to act, others still, lead an inconsistent life (i.e. going to the doctor when it is really bad, but otherwise doing nothing).

H2: And if I see myself as already fat, and saying that I'm fat, I begin to say, "so what?", that's they way you want to stay.

H5: There are people…I have some associates that don't give it much importance. They don't take care of themselves. And I think that sometimes people live with it like anything else. But not something they consider so much as a disease. It's a condition. But that's the feeling I get…really I can't answer too much there. Because I'm from another culture.

H5: And here I get the feeling that it is a little more assumed as a part of something that can happen to you in life. Just like you can be left unemployed, just like you become lame, or something like that, I don't know. There is a certain fatalism in Mexicans that things can go bad and you accept it and continue on happily.

P3:
C: They say, "I'm fat, but I'm happy." What type of mentality is that? And for example, for us being our age, it's no longer easy to lose weight.
O: Well, you have to forget that.
M: Well, yes. But for me…because I can't. I want to be a certain weight, but I still can't.

The perspective of H5 is again particularly interesting here because she is not from Mexico. Through her time spent here she has observed this feeling of fatalism. The idea that diabetes is assumed as something that just happens like any other occurrence in life is certainly a notion that could inhibit its treatment. If people accept it as another facet of life then they will not take the ameliorating steps and continue the treacherous cycle of the disease. The doctor (H2) pointed directly to these types of people who, for example, simply accept that they are fat, shrug their shoulders, and move on expecting nothing different.

The final comment came from the wife of the diabetic (P3) who displays this exact sentiment. First, she spoke disapprovingly of those who hold the idea that they are "fat but happy," but then contradicted herself by saying that she could not lose weight because of her age. Her contradiction is even more emphasized when the doctor said she needed to forget that idea, and she reiterated that although she would like to be a certain weight, she simply cannot lose weight. So, there is this tension between knowing that there is something wrong with simply accepting things the way they are, and holding the belief that for oneself there are some things that cannot change.

There is no doubt that this culture of *fatalismo* feeds into the idea iterated by some in the interviews that overall people in this city simply do not give enough importance to health issues.

J1: Clearly, but the people of Mexico, well here in Michoacán, we are deciduous when it comes to illness. With that I am referring to those who don't give it any importance. In other words they know that it's mortal, that is treatable, and but that it's serious, but it is as if they ignore it. They ignore illness. As with cancer.

Erroneous notions. Many of the cultural or personal beliefs talked about in the interviews were mentioned because of their erroneous nature. These blatantly false ideas pervade the population and produce negative images of not only diabetes, but also the treatments.

J2: For example there is a lot of infantile diabetes in Mexico. And the mothers believe that they aren't going to live, that they are going to die, that they are going to cut off a foot. And it's not like that.

J3: And they believe that diabetes can be cured. I can assure you that there are a lot of people who do not know that diabetes doesn't have a cure. But there are those who believe there is a cure.

H1: Well, there are many myths that are still around. Like insulin can leave you blind.

H2: Ok, as Mexicans, being a little overweight and a bit chubby gives the aspect that we are healthy.

H2: In Morelia when they advertise meetings or conferences that specifically say the word "diabetes" you will see amongst the audience, not only are doctors, nurses, or health sectors trying to register, but there are people that are fathers, people with diabetes that do it because "well, what is there now?" With a hope that it will cure them. Or "what miracle medicine are they investigating now?" And I'll take it a bit further, "I would like to be a guinea pig for a researcher, with hopes that they can cure me of diabetes."

Erroneous notions, like the idea that insulin can make you blind, or believing that there is a cure for diabetes does incredible harm to the campaign against diabetes and against the citizens of Morelia themselves. If one believes that the treatment will do more harm than good, there is little hope of getting that person to obtain the necessary help. The longer such an individual is hindered by such a belief, the worse his or her condition will be when he or she finally seeks the appropriate help and begins the appropriate regimen.

Perhaps even worse is the highly erroneous idea that there is a cure for diabetes. This could result in the delay of treatment in hopes of procuring an instantaneous and permanent cure. As the doctor (H2) indicated, this idea leads people to actively seek out a cure, hoping for the chance to be the first test subject to participate. No doubt when they discover the truth, there are

additional consequences—more stress, vast disappointment, and all of the other negative emotions that come with realizing that this is a condition that they will have to deal with for rest of his or her life.

Here we have a set of schema that are simply wrong. These misconceived schema of diabetes and its treatments have to be completed displaced. Frames need to be constructed that connect these erroneous notions with the truth. It would probably not be as effective to simply create the truthful frame alone, because the wrong ones have to be undermined.

CHAPTER 6

IMPLICATIONS

Implications for a Health Communications Campaign in Morelia

The most important and useful implications from this case study for designing a health communications campaign on diabetes in Morelia can be found by highlighting which frames and schema each group emphasized during the conversations. This invaluable information comes largely out of the qualitative aspects of the conversations, however, the quantitative implications support these findings. When looking at the number of mentions of a frame or a schema, the amount of times it was mentioned show at a glance what aspects would be most important to focus on in one or various campaigns. Upon delving deeper into the interviews and putting them into context, one can truly begin to unravel how these key players framed the issue of diabetes and what impact proper use of this information could have.

Implications for Journalists

The frames and schema most mentioned by journalists were prevention, cost, social self, and personal and cultural beliefs. An effective news media component of a campaign against diabetes in Morelia would be appropriate, especially because these journalists would be quite the advocates.

Prevention. Journalists recognized the importance of reporting prevention information, and tried to use a prevention frame whenever possible in an article related to diabetes. However, they acknowledged that it was not always easy to do, because many times their editors found this personal care advice “unsexy”. They admitted that the editors are more dazzled by statistics and

get more attention. The challenge here for journalists becomes to present this crucial advice strategically, so that it both appeals to editors and provides substantive prevention information to the target audience. Journalists must find a balance between the spectacularly sexy statistics, and the seemingly mundane, but ever so imperative measures of prevention that will increase readers' awareness and hopefully cue them to action. They must impress upon their editors that though this information is not always headlining news, it is of the utmost importance to continually transmit.

Cost. Journalists report frequently on the healthcare costs of diabetes in the city. A news media campaign could take advantage of the cost frame by emphasizing that failure to manage diabetes is much more expensive than controlling it. Appealing to the financial sense of individuals could show them that they could save money by staying healthier.

Additionally, journalists should focus on the broader societal costs of diabetes. The fact that so much of the health care budget goes to diabetes and chronic diseases, inevitably limits medical services in other sectors. It is not only those with diabetes who suffer, it is everyone. If a citywide effort were made to substantially decrease diabetes, the associated public health costs would decrease, and the health sector could provide better services in other areas where money is needed. The savings could affect other parts of the society as well. The money could be redirected into various public or government areas, for example, to infrastructure or education. Journalist should use the monetary frame to make the citizens of Morelia more aware of these possibilities.

Social-Self. In the social-self category journalists talked about the stigma of diabetes, particularly as a "silent killer." A campaign could take advantage of the stigma schemata by creating frames that include more exemplars of diabetes. Exemplars are personified examples

that illustrate particular threatening condition (e.g., Juan has suffered with diabetes for 10 years. When he finally sought help, his conditions were well in the advanced stage.) (Niederdeppe et al, 2008). However in using these types of frames, journalists must be sure to provide ways that readers can deal with the prospect of having diabetes, so that they do not become overwhelmed and dismissive of the messages (Witte, et al., 1996).

None of the reporters ever mentioned that they had used narratives to highlight the insidiousness of diabetes, and this could have a more dynamic and personal effect. However, in approaching diabetes from a narrative standpoint journalists must make sure to frame the disease as a public health issue. Communication about certain health topics tends to target and blame individuals. This could be remedied if journalists took a thematic approach as Niederdeppe suggests, spreading the responsibility to the macro- and meso- levels.

Personal and cultural beliefs. Journalists also mentioned the personal and cultural beliefs and the role they play in inhibiting some citizens from taking care of themselves properly. However, when asked had the journalist ever directly addressed these beliefs in articles two journalists replied that they had not. Journalists could begin the deconstruction of many of these beliefs by presenting a simple side-by-side comparison of these erroneous beliefs and actual truth.

Disease rates, disparities, risk factors. Journalists mentioned disease rates, disparities and risk factors proportionately. Given that patients did not mention the first two categories, journalists using these frames may want to make sure that when they report on diabetes statistics that they explain thoroughly what this information means for an individual as well as what it means in the bigger picture. The disparity frame could be particularly effective in making comparisons to other cities, states, or countries. In making clear comparisons, the citizens of

Morelia can begin to truly capture the gravity of these numbers, and realize how the city fairs against others with respect to the disease.

Implications for Health Professionals

Health professionals mentioned prevention and social self most frequently; and cost, personal and cultural beliefs, lifestyle modification, and stress and emotion recur moderately throughout the interviews.

Prevention. Health professionals mentioned prevention the most, referencing the overall lack thereof, advising patients on certain preventative measures, and acknowledging that prevention is the most important factor in curbing the rapid increase in diabetes in the city. It is clear that a large component for an effective citywide campaign must include a prevention aspect, because prevention will be the most effective way to bring down the current diabetes rate. As many of the health professionals suggested, this information should be targeted at the school-aged populations, taking the form of health education classes in order to indoctrinate citizens from youth.

Social-self. In the social-self category, health professionals observed the growing family support that diabetics have received. Health professionals, whether in a medical setting or a media campaign, should continue to frame diabetes as a family concern that requires everyone's participation. Socially, they should continue to frame diabetes as a public health issue, and continue the empowerment of people with diabetes through awareness programs and recognition events.

Cost. With respect to cost, health professionals have the same opportunities as journalists to appeal to the financial sense of their patients by expounding on the monetary costs of diabetes. Health professionals could frame patient visits or campaigns to delineate the costs of buying

fresh fruits and vegetables, or purchasing a gym membership versus the costs of quarterly visits to the doctor, paying for a lifetime of medication, and worse, the cost of amputations or kidney transplants.

Personal and cultural beliefs. Health professionals in Morelia should begin to approach the personal or cultural beliefs that impede some from taking action against the disease. Targeting these beliefs at various levels would slowly supplant the erroneous beliefs, replacing them with current and factual ones. The key word here is "slowly," because these ideas have been ingrained for years, and it will take even longer to uproot them. Doctors should be addressing these types of concerns at the patient visits, and health communicators should be creating materials to dispel misinformation. These materials could be handed out at public health events, screenings, and distributed in clinics and hospitals.

To combat the pervading fatalism of Mexican culture, a campaign should use an approach that says, "*your* health is in *your* hands", or "what *you* do matters to *your* health," or "if *you* don't do something, nothing will happen." Essentially, the campaign has to create more acceptance and accountability of one's own health.

Lifestyle Modifications. In addressing the lifestyle modifications with which a diabetic must comply to stay healthy, a campaign needs to be sure and educate people as to *why* they are making these changes. A campaign cannot rest on the idea that people will receive this information with pleasure and implement it into their lives with facility. Whatever the medium, an increased effort to educate on these modifications should be considered. People need to understand what they are doing, and this comprehension will aid in maintenance.

Stress and emotions. Health professionals should make sure to approach diabetes holistically to treat both the physical and psychological being. On the individual levels doctors

should continue to be concerned with the mental well being of people with diabetes, and provide advice for dealing with the depression or fear that can accompany the illness. On a larger scale a health communications campaign needs to raise awareness of the mental toll that diabetes can take and how these may present themselves as symptoms of diabetes.

Implications for Patients

Patients mentioned lifestyle modifications and prevention most frequently; and stress and emotion, social self, and consequences were all mentioned moderately.

Lifestyle Modification. This is not a difficult frame to implicate into a campaign, however in Morelia, it may be one of the most difficult to infuse into its citizens. Patients talked a lot about the struggles of maintaining the seemingly arduous and foreign life changes that accompany being diagnosed with diabetes. Asking people to completely give up their traditional and favorite foods is a dangerous move that is likely to be ineffective. Instead, a campaign should focus on the ideas of "everything in moderation," and some things a bit less than that. This sense of moderation is an important aspect to begin in order to pass down to future generations. But this message should not convey the sense that they have to abandon their culture. Again it is important to education people on why they are making these changes.

A campaign implementing frames to address lifestyle modifications should avoid the negative ideas of "giving up" things, and be careful even using loaded words like "exercise," which connotes strenuous and enduring physical activity. It should let people know that simple daily activities can be used as exercised. Also, it should focus on the health, richness of life, and years that will be gained due to those lifestyle changes.

Prevention. Patients recognized that preventative information is out there, but also admitted to observing inaction when came to health. Some of this advice should target the youth,

for example in health education classes in school. These health messages and programs need to focus on healthier eating habits, encourage more physical activity, and emphasize the consequences of neglecting to do either. Also, target young parents because they are the ones buying the food and the ones who encourage the activities in a child's life.

When targeting prevention behaviors to adults, a campaign should explore more dynamic ways of presenting the information, so that it cannot be as easily ignored as current methods. A highly visible and penetrating awareness campaign that saturates the city with the preventative instructions a few times a year could have a significant effect. And though this would probably still not capture all of the target audience's attention, even a slight increase in those who respond to prevention methods could result in even a significant chipping away the problem.

Stress and Emotion. Many patients talked about the stresses and bouts with emotions that they go through with diabetes. It is encouraging to see that doctors are tending to these emotional needs as well, even though many times patients were not aware of the mercurial stages that can accompany diabetes.

A campaign directed at this issue should use a frame that encourages the holistic approach mentioned earlier. This approach should include the notion of self-esteem needs, which one doctor said is not necessarily linked to health in Mexican culture. Women for example, often gain weight and become obese because they feel useless after their children leave home. A smart anti-diabetes campaign would include a component to promote women to think of themselves as more than just a wife or mother, and encourage them to find other interests in order to have a fulfilling life after this chapter of the lives ends.

Social-Self. It is encouraging to note that the schema associated with social-self are positive, and this is a case where frames should reinforce. Patients and family members had

either observed or benefited from growing family support, a higher recognition of diabetes as a public health issue, and the continuing empowerment of people who have diabetes.

Given that the family unit is such a nucleus in Mexican culture, it should be a natural step to get family members of individuals with diabetes more involved. The key however, is to more precisely frame the type of involvement. A campaign should focus on family members participating in or adopting some of the changes that a person with diabetes must implement. The focus should be on making the entire family healthier through better diet and more exercise, as opposed to simply monitoring the person with diabetes.

A campaign should definitely frame diabetes from a societal and public health point of view. The frame should include the ideas of fighting diabetes as a nation, state, city, and community, because it is indeed a disease that affects each and everyone, whether an individual has diabetes or not.

Lastly, a campaign should strive to promote the wonderful efforts currently taking place in the city that increase diabetes awareness and reward those who are thriving in spite of the disease. If possible, new programs should be created.

Consequences of treatment. The interviewees were well aware of the personal and large-scale repercussions of diabetes. Patients were mainly interested in the life-threatening results of improper care (though many times do not act), and doctors focused on the consequences of treatment. This is a case where a frame needs to be shifted or added to the target group's point of reference to make a campaign more effective overall.

A campaign should focus on getting patients to more readily, effectively, and more deeply realize and understand the benefits of self-care treatment. The campaign has to thoroughly convince and educate its audience of initiating treatment, maintaining that treatment,

and understanding that this is a lifelong effort. And though this effort seems to come at the costly price of diligent maintenance, the reward of a longer healthier life is worth it.

Implications for a Health Communications Campaign in the U.S.

There are several implications from this research that extend from Morelia to the U.S. These can be found largely in the perspective frame, specifically the prevention frame; and from the socio-cultural schema section.

Prevention. As in Morelia, a communications campaign targeting Mexicans or Mexican Americans in the U.S. must include a prevention component and occur place at various levels. Doctors who treat Mexican American patients should explore family history with them and explain the genetic predisposition for developing diabetes among Latinos. If a patient's family has a history of diabetes, a doctor should apprise him or her of the symptoms, and of the crucial lifestyle steps that one can take to avoid developing diabetes. Particularly, doctors should pay attention to diet and exercise, advising their patients that many times when Mexicans emigrate to the U.S. the drastic dietary changes often contribute to rapid obesity.

On a societal scale, given that Latinos are the fastest growing population in the U.S., public health campaigns must address prevention concerns of diabetes and Latinos. Mass media and news campaigns should directly target Latino audiences to raise awareness of this information and encourage detection. Media efforts should use English, Spanish, and Spanglish to communicate most efficiently. Designers should take into considerate the local dialect of Spanish or Spanglish.

Socio-cultural Schema. Much of the schema that the citizens of Morelia associate with diabetes will follow them in their journey to the U.S. and continue to be passed down to their

children. A campaign targeting these beliefs or wishing to take advantage of them should be sure to consider all of the cultural attachments that go along with each of these schemata.

Social Self. U.S. Healthcare providers and health communicators should strive to take advantage of the familial aspects of the Mexican culture. Specific measures could be the inclusion of family member in medical visits and decisions. Doctors should be open to having another or several family members attend a visit. The doctor should incorporate present family members into the visit and into the self-maintenance that takes place at home. By encouraging these family members to eat healthier and take more exercise just as the patient must, the doctor could begin healthier trends for the entire family unit.

A campaign should provide exemplars to people at risk for diabetes, perhaps using vivid illustrations through various media methods.

Natural Therapies. The schemata associated with natural therapies are more important to consider from the U.S. side. Use of these therapies is still prevalent in Mexican culture and can potentially interfere with medical treatment regimens. This topic should be approached with much cultural sensitivity and doctors should consider an approach like that of Dr. Ortiz, who said that he advised that as long as the patient is following his medical advice these innocuous remedies are permitted. It is important that doctors consider the cultural ties to these remedies and not to scold a patient for using them, but instead to educate that though these supplements may be healthy, it is of the utmost importance to properly follow all medical advice provided.

Personal and cultural beliefs. The former sections have already hit on the importance of knowing and understanding the cultural beliefs that Mexicans and Mexican Americans have with regards to diabetes. It the health professional's job to understand how to approach these views and to address them appropriately. Health professionals must realize that these notions will not

be “cured” with a few doctors’ visits, and may never be corrected for some. They must instead be diligent and consistent in providing accurate information at each visit. Doctors should make a concerted effort to inquire about how their patients feel about having the disease and what they may have heard that worries them. This would provide insight to where that individual is in his or her thought process, which would be useful in the treatment process.

Overall, understanding the frames and schema that Mexicans and Mexican Americans possess about diabetes is a necessity for American health care organizations, public health entities, and private health research companies in fighting the disease in this population. Campaigns should be sure to target Mexicans and Mexican Americans as an individual target groups as much as possible (i.e. Not just a blanket campaign for ALL Latinos). Experts must approach the issues always keeping in mind that many of the frames are endemic to Mexican culture and that we cannot always impose American frames on Mexican mindsets.

CHAPTER 7

LIMITATIONS AND FUTURE RESEARCH

Although this study achieved an in-depth look into the perceptions of three important groups concerning communication about diabetes in Morelia, there are other groups to consider when creating a campaign against diabetes. Everyday citizens who are not directly affected by diabetes were not interviewed. This would be an important audience to consider in future research because many in this audience are susceptible to developing diabetic. Also, this would be a key target audience for an awareness campaign because this audience is most likely not as concerned with the gravity of the disease as those who are already affected in some way. A large part of the prevention aspect would have to include the views of this audience.

When examining the quantitative aspects of the study it is important to consider that some of the mentions could have fallen into various categories and the researcher ultimately decided where to put them. This approach is not as precise as using a strictly a content analysis approach, though in this case the categorization of the interviews are not as important as the content itself. Also, some of the questions included in the interview guide or brought up by the researcher more likely elicited responses about certain categories than others, subsequently increasing mentions on some categories and suppressing mentions in other areas.

Future research should also try to ascertain views from health professionals in other settings such as hospitals. Additionally, future research should investigate other media (i.e. television, internet), especially those that have been used for specific campaigns on diabetes.

CHAPTER 8

CONCLUSIONS

There is much work to be done in Morelia with respect to diabetes, however there are also hopeful signs that this work has begun or is underway. Beginning the deterioration of the intense effects of a disease such as diabetes takes time. Much of this time must be taken to reframe many of the aspects of the disease highlighted in this study. Some of the cultural frames, constructed around tradition and misinformation—such as erroneous notions—are still very valid frames of reference for a certain section of people in this city. Other frames are beginning to change or are in the transition phase, such as regarding diabetes as a public health issue. Others still, such as familiar support, seem to have been almost completely reframed, and simply need a bit more emphasis and focus.

In every frame analyzed here more education needs to be implemented. Public health communicators and policy makers in Morelia have a large task on their hand with respect to education. On one hand, they must infiltrate the existing education system with the proper courses to target the current youth of Morelia. On the other hand they must also find novel ways to catch the attention of and inform the current adult population. Additionally, this job is made ever more difficult by the audience who knows the information but chooses not to act. This is a seemingly large group that persists even with the knowledge that they are susceptible.

Knowing and understanding the present frames and schema about the disease gives those who communicate about it insight to where a campaign should begin in trying to reframe particular aspects of diabetes. And though this reframing will take much effort and time, once

these frames have been accepted as general knowledge they should persist in the future as cultural frames for a substantial amount of time.

REFERENCES

American Diabetes Association. (2009). Genetics of Diabetes. Retrieved on January 13, 20, from: http://www.diabetes.org/diabetes-basics/genetics-of-diabetes.html.

Barceló, A., Aedo, C., Rajpathak, S., & Robles, S. (2003). The cost of diabetes in Latin America and the Caribbean. *Bulletin of the World Health Organization,* 81.

Beamer, L. (1995). A schemata Model for Intercultural Encounters and Case Study: The Emperor and the Envoy. *The Journal of Business Communication, 32*(2), 141-161.

Clarke County School District Migrant Education Program. (2008). Program Census.

Dahinden, U. (2005). Framing: A decade of research experience. International Communication Association Conference Papers, 2005 Annual Meeting. New York, 1-9.

Entman, R. (1993). Framing: toward clarification of a fractured paradigm. *Journal of Communication, 43(4),* 51-58.

Fieleke, N. (2007). Cultural framing of diabetes from a public health perspective: A comparative content analysis. University of Missouri-Columbia. Master's Thesis.

Gitlin, T. (1980). *The Whole World is Watching: mass media in the making & unmaking of the new left.* Berkeley: University of California Press.

Goffman, E. (1974). *Frame Analysis.* Boston: Boston Northeastern University Press.

Hallahan, Kirk. (199). Seven Models of Framing: Implications for Public Relations. *Journal of Public Relations Research, 11* (3), 205-242.N

National Institute of Statistics and Geography (INEGI). (2010) Statistics for world population day: Data for Michoacán de Ocampo.

Kahneman, D. & Tversky, A. (1983). Choices, Values, and Frames. *American Psychologist, 39,* (4), 341-350.

Loewe, R., & Freeman, J. (2001). Interpreting diabetes Mellitus: Differences between patient and provider models of disease and their implications for clinical practice. *Culture, Medicine and Psychiatry, 24*, 379-401.

Medina, A. L. (2008). Aumenta 5 por ciento casos de diabetes en Michoacán. *El Sol de Morelia.*

Medina, A. L. (2008). Diabetes, primera causa de muerte en adultos mayors. *El Sol de Morelia.*

Medina, A. L. (2009). Por cada diabético, hay otro que no se sabe enfermo. Registra la SSM a 25 mil en todo el estado. *El Sol de Morelia.*

Menashe, C. L. & Siegel, M. (1998). The power of a frame: an analysis of newspaper coverage of tobacco issues—United States, 1985-1996. *Journal of Health Communications, 3,* 307-325.

Meyerowitz, B. E., & Chaiken, S. (1987). The effect of message framing on breast self-examination attitudes, intentions, and behavior. *Journal of Personality and Social Psychology, 52*(3), 500-510.

Popham, W.J., Potter, L.D., Bal, D.G., Johnson, M.D., Duerr, J.M., & Quinn, V. (1993). Do Anti-Smoking Media Campaigns Help Smokers Quit? *Public Health Report, 108,* (4), 810-813.

Niedeppe, J. Bu, L. Q., Borah, P., Kindig, D. A., Robert, S.A. (2008). Message Design Strategies

to Raise Public Awareness of Social Determinants of Health and Population Health Disparities. *The Milbank Quarterly, 86,* (3), 418-513.

Rodriguez, K. (2007). Mexican-American Health Beliefs and Diabetes: A Culturally Appropriate Campaign Proposal. Paper presented at the annual meeting of the NCA 93rd Annual Convention, Chicago, IL. Retrieved on January 20, 2009, from: http://www.allacademic.com/meta/p193915_index.html.

Scheufele, B. (2004). Framing-effects approach: A theoretical and methodological critique. *Communications, 29*, 401-428.

Scheufele, B. (2006). Frames, schemata, and news reporting. *Communications, 31*, 65-83.

Scheufele, D. (1999). Framing as a Theory of Media Effects. *International Communication Association,* 103-122.

Siegel, M. & Biener, L. (2000). The Impact of an Antismoking Media Campaign on Progression to Established Smoking: Results of a Longitudinal Youth Study. *American Journal of Public Health, 90,* (3), 380-386.

Reese, S. D., Gandy, O.H., Grant, A. E. (2001). *Framing Public Life.* London: Lawrence Erlbaum Associates.

Rosenberg, C. E. (1989). Disease in History: Frames and Framers. *The Milbank Quarterly, 67,* (1), 1989.

Rothman, A. J., Salovey, P., Antone, C., Keough, K., & Martin, C. D. (1993). The influence of message framing on intentions to perform health behaviors. *Journal of Experimental Social Psychology, 29,* 408-433.

Tversky, A., & Kahneman, D. (1981). The framing of decisions and the rationality of choice. *Science, 221*, 453–458.

Van Gorp, B. (2007). The Constructionist Approach to Framing: Bringing Culture Back In. *Journal of Communication, 57,* 60-78.

Vreese, C. H. (2005). News framing: theory and typology. *Information Design Journal, 12*(1), 51-62.

Warner, K.E. (1977). The Effects of the Anti-Smoking Campaign on Cigarette Consumption. *American Journal of Public Health, 67,* (7), 645-650.

Witte, K., Cameron, K. A., Mckeon, J. K., Berkowitz, J.M. (1996). Predicting Risk Behaviors: Development and Validation of a Diagnostic Scale. *Journal of Health Communication, 1,* 317-341.

World Health Organization. (2009). Country and Regional Data. Retrieved on January 11, 2009 from: http://www.who.int/diabetes/facts/world_figures/en/ .

World Health Organization. (2009). Diabetes Progamme. Retrieved on January 11, 2009 from: http://www.who.int/diabetes/actionnow/lifethreatening/en/.

World Health Organization. (2009). Diabetes- who is at risk? Retrieved on January 11, 2009 from: http://www.who.int/diabetes/BOOKLET_HTML/en/index6.html.

Yin, R. (1989). *Case Study Research*. Sage Publications. Newbury Park, California.

Zoch, L. M., & Molleda, J. C. (2006). Building a Theoretical Model of Media Reations, Using Framing, Information Subsidies, and Agenda-Building. *Public Relations Theory II,* 229-309.

APPENDICES

APPENDIX A

THE INTERVIEWS

Interview with Humberto Castillo Mercado, Reporter for El Cambio de Michoacán (J1)

E: Bueno, para empezar, si me decir tu nombre y tu profesión, y donde trabaja.
H: Soy Humberto Castillo Mercado. Soy reportero, periodista, estudio comunicación. Trabajo para Cambio de Michoacán, aquí en Morelia.
E: ¿Y con respecto a la educación, si fuiste a la Universidad? ¿Y donde?
H: Sí fui a una Universidad privada en la ciudad de México, estudio periodismo.
E: ¿Y eres de Morelia?
H: No, soy de un municipio que se llama Nueva Italia, aquí en Michoacán. 180 Kilómetros de aquí, mas o menos. En la tierra caliente.
E: No, conozco.
H: Rumbo a la costa.
E: A ver, primero, ¿como periodista, qué importancia cree que tiene hacer notas sobre la diabetes aquí en Morelia?
H: Bueno, en Michoacán, las estadísticas son muy altas sobre esta enfermedad. Y no estamos exentos, ni los adultos, ni los niños de que de padezcamos bastante mal. Y creo que en Michoacán la secretaria de salud ha hecho bastante difusión sobre lo que es la diabetes mellitus. Y las consecuencias, también el seguro social. Aquellos que son hipertensos y todos lo que pudiéramos padecer la enfermedad. Que creo que se ha hecho trabajo de prevención y ya después para los pacientes que tienen la enfermedad. Es muy interesante cuando yo he ido a prensas al seguro social, conocer las causa, los motivos, las razones, porque, cuales son las síntomas y quienes la pueden padecer a veces hasta espanta. Se espanta uno de todo lo que puede generar la diabetes.
E: ¿Ya ibas mencionando algunas, pero cuales aspectos de la enfermedad te parece que es lo mas importante enfatizar en una nota?
H: Luego los periodistas le damos mucho por las estadísticas. Y que " el 30% de los michoacanos padecen diabetes," o "estamos expuesto a tantos," o que "los niños también son diabéticos." Pero creo que lo mas importante es conocer la enfermedad. Que lo ocasiona, como se previene. Seguro que lo mas importante es las medidas de prevención. De informarla a la gente de cuando me siento cansado, con flojera, es que soy candidato. Pero, un urgente para esa enfermedad. Creo que mas real de las estadísticas es la información de los medios de comunicación. Mas que hay estadísticas de cuanto se muere. Bueno también es importante darlas, porque informas a la población y terminas hasta espantas. Pero si es de importante informar, hacer lo que es trabajo social. Como medio tienes que contribuir de manera social. A que la gente que no padezca mal la enfermedad, o a los que están ya con la enfermedad. Pues también se atiende.

E: ¿Y crees que sí, ya lo hace lo suficiente sobre la prevención, con respecto a El Cambio de Michoacán. Y también con otros medios de comunicación?
H: ¿Que si hay la información suficiente en difusión? Yo creo que nunca es suficiente. SE le da mucha importancia en este periódico, y en otros. Si se le da lo suficiente. Pero, creo que hay un falta. Falta también que las dependencias hagan mas, hay campañas permanentes y hay todo, pero no solamente cuando las dependencias nos invita o nos convocan. No solamente cuando el gobierno diga, "vamos a hacer esto de la diabetes," sino que también los medios de comunicación deben de ir mas allá. Ir con pacientes, ir a las instancias de salud, digamos al seguro social, el centro de salud, a los hospitales. Eso ha faltado mas. Entrevistar a la gente, que tienen familiares que han muerto. Todo esto.
E: ¿Y que crees es la mejor fuente para los morelianos para conseguir información sobre la diabetes?
H: Pues, es la secretaria de salud y el seguro social. Y también puede hacer fuentes algunos pacientes u organizaciones que hay de diabéticos. pOrque hay hasta organizaciones de gente que ya padece.
E: ¿Y medios de comunicación?
H: Ah, claro.
E: ¿Pero incluso todos, a donde van la gente para conseguir la información? Mas bien el Internet?
H: Ah, las fuentes. Eh, puede ser el Internet. La radio, la televisión. El problema es de que aquí no es como en los EEUU, de que la gente busca información. Yo creo que es muy poca la gente que utiliza el Internet para buscar dato de diabetes, o que quiere decir diabetes, o que quiere decir X enfermedad o cuales son las medidas de prevención. Desafortunadamente, falta mucha educación. El 3 o 4% de la población lee periódicos. Y un porcentaje también mínimo escucha radio y ponerle atención a las cuestiones de salud. Y la mayor parte de la gente ve tele, y después radio, y después la prensa escrita. El Internet no sabría donde está ubicado. Pero, bueno, si forma parte importante de la consulta. Pero, falta educación, sobre todo es la mas importante. Para estar informados y para tener la información adecuada.
E: ¿Quién debería difundir la información?
H: Pues creo que es las autoridades de salud o sea al gobierno. Y también los medios de comunicación.
E: ¿Y por ejemplo en el Cambio de Michoacán cuanto de menudo escribes tu o quien sea sobre esto?
H: Uy, es poco la verdad. Digamos que una vez al mes el promedio. O hay veces, una vez a la quincena. Eh, podrás ver en Internet hay veces que son un día otro día, y después pasa un mes, y nada. Y hay veces que son dos días seguidos y después transcurren quince días o una semana tal vez. Pero creo si que falta mas inherencia de los medios sobre este tema. Que claro, eso y el cáncer son los mas que difunden. Pero aun así es poco, relativamente.
E: ¿En tu opinión, como crees que sienten los morelianos sobre la diabetes? Si, no se, ellos creen que es tan problema como tu?
H: No, entendí.
E: ¿Si la gente de la cuidad creen que es tan problema que se dice?
H: Creo que lo que siente la gente o lo que yo percibo de lo que piensa la gente, o de lo que dice la gente, no es tan…para mi es un problema de salud grave, un problema de salud publico. Pero al resto de la gente no. Y menos para los jóvenes. O sea y para los niños menos. Aunque también hay casos de niños también. La gente hasta que no tiene 35 años o treinta y tantos, y que empieza

a veces con el mal estar, y que toma mas conciencia. Ni los adultos. Tengo un tío en Nueva Italia que se murió en noviembre de consecuencias de la diabetes. Ya no podía caminar, tenia una pie podrido, etc., un dedo creo. No se si le llago hoy. Como vivía solo, no tenia mujer, no tenia hijos. Y era campesino así que al abandono. Y cerca de ahí vivía mi tía, otra tía, como de 50 años que trabaja, es madre soltera, es viuda. Entonces sabe que tiene la enfermedad. Sabe que se pone enferma, pero no deja de beber Coca-cola, no deja de comer carne, y esas cosas.
E: ¿Así tu dijiste que no deja de beber coca-cola y todo esto. ¿Pero crees si se dan cuenta que esas cosas les afecta tan negativamente?
H: Claro, pero la gente de México, pues aquí en Michoacán, somos muy decidíoslos para las enfermedades. A eso me refiero con esos ejemplos de que no le dan importancia. O sea, saben que es mortal, que es tratable, pero que es grave, pero que como que la ignoran. Ignoran las enfermedades. Como el cáncer.
E: ¿Y a ti que tipo de cosa te gustaría ver , con medios de comunicación o no tiene que ser una campaña, pero algo que tu crees que puede ayudar que la gente entienda o que oiga?
H: Yo creo que diseñar programas, políticas públicas, digamos mas difusión constante, permanente en los medios informativos. En las escuelas por ejemplo. Creo que falta qué en la educación básica, digamos en primaria, secundaria, haya educación para la salud. Educación de la salud. Y que desde ahorita los niños que están en primario, se les empiece a hablar de esto, no? Porque es un problema de salud pública. Por al menos también en Michoacán es muy grave. Y los padres, pues no lo hacen. Entonces le corresponde también a la secretaria de educación. Que se incluyera en los libros de textos estos temas. Que se hablara mas de esto, porque si lo hacen pero de muy superficial. Y para que cuando ya seas adulto estés mas consciente. Porque no hacemos ejercicio o hacemos muy poco. En las escuelas ya se empieza a hacer algo, ya no se permite la comida chatarra. Precisamente por lo mismo, y a que lo tienen informados. Ya sabes, no? Pero hay una ley que esta probando que aprobó la cámara de diputados aquí en Michoacán. Pero, ve a cualquier escuela y ves que venden chicharrones, este refrescos. Yo hasta quiero hacer una nota de eso. De que hay unas escuelas en las colonias populares, y en las colonias marginadas o pobres o jodidas es donde mas se vio esto. A lo mejor el las colonias particulares y de niños bien y gente de nivel, pues no viden. La mama les ponen su frutita en un termo o en una bolsita. Y lo llevan así. Hay escuelas por aquí cerca y no dejan entrar vendedores. Entonces las madres van y les llevan sus frutita o sus tacos o su torta. Pero hay otras donde adentro de la escuela, las puertas están cerradas, pero venden chicharrones, gorditas, dulces y porque ahí en medio. Entonces eso, falta mas cuidado, mas atención. Que en las escuelas haya un medico, y en ninguna hay. O sea, a lo mejor en algunas privadas hay.
E: Ah, ¿no?
H: No aquí no hay médicos, ni sicólogos en las escuelas. O sea, con trabajos sí hay un botiquín. Pero no hay ni siquiera una enfermera. O sea sin un niño esta enfermo ya una vez la maestra lo ve y “vete para tu casa hijo”. Ya. Pero aquí no te revisan. Pues entonces pues desde ahí. No todos se lo pude dejar al gobierno. Pero la educación, pues sí.

Interview with Astrid del Ángel, Journalist at La Voz (J2)

E: Primero, me puedes dar tu nombre, en que trabajas, tu nivel de educación y tu edad.
A: Mi nombre es Astrid del Ángel, soy periodista. Cubro la fuente de salud en la voz de Michoacán. Tengo 23 años. Y termine hace 6 meses la licenciatura en ciencias de comunicaciones.
E: ¿En cual universidad?
A: En la Universidad Latina de América.
E: ¿Y es de Morelia?
A: Pues, tengo viviendo aquí casi toda mi vida.
E: Primero, ¿como periodista qué importancia cree que tiene la diabetes aquí en Morelia.
A: Como tú bien lo manejas. Es una de las principales enfermedades de no solo de Michoacán, sino de México entero. Tenemos altos índices de obesidad lo que vienen también como consecuencias de la diabetes. Y también es un problema genético de los hispanos. Entonces difundir temas sobre esta enfermedad que se puede prevenir, que se puede retrasar pues es muy importante para la gente que esta muy de este lado, no? Y que tenemos la opción a llegar a tantas personas.
E: ¿Y también a tus editores y a tus directores ven la importancia?
A: Si. Fíjate que este periódico, tiene un, ahorita sobre todo, es reciente esto que esta manejando el periodismo de servicio. Que es precisamente eso, que no sea tan solo de "hay tantos diabéticos". Pero a donde pueden ir. Como se puede prevenir. Que se puede hacer. Y es lo que estamos tratando de hacer, en el periódico. Darle a la gente elementos para que sepan que hacer o como prevenir. Y en ese caso los editores y en general los directivos están muy abiertos a tratar los temas de salud. Que sobre todo mandos que se puede prevenir. Y que tanto afecta. Y que también es un gasto fuerte para el gobierno, tratar a todas estas personas.
E: ¿Y a la gente de Morelia en cual aspecto se enfocan ella?
A: Pues, yo creo que a la gente le gustan mas las cifras: "Tantas personas se mueran de la diabetes!". Les interesa mucho. Y a lo mejor no lo toman la importancia que debieran a la prevención. Sin embargo, es machacar y machacar y repetirles y repetirles la información. Para que de esto modo la poquito que se te quede, "el día de hoy no me voy a tomar la Coca y voy a tomar el vasito de agua". Creo que si es importante. Y creo que si la sociedad debe de cambiar un poquito, y pues nosotros podemos ayudar.
E: ¿Y como tu dices de cambiar la sociedad, en que sentido específicamente?
A: Pues en la prevención creo que esta todo. En los chiquitines, en los niños si les empezamos a enseñar que las cosas naturales son mejores, que no hay que tomar tanto azúcar. Pues creo que vamos a tener una sociedad con menos enfermedades, cuando ellos estén grandes. Sin embargo, pues debemos tomar en cuenta que los adultos son los que enseñan a esos chiquitos. Los niños no leen el periódico. Entonces, pues, hay que asustarles un poco. Porque si no, no entienden. Si no les dices que se puede morir, que es de verdad, no captamos, no hacemos caso.
E: ¿Así que no crees que hay la suficiente sobre la prevención, así que la gente cuando hablan sobre la enfermedad, de que parte hablan.
A: Es que te digo los Mexicanos son muy amariguistas.
E: ¿Qué quiere decir?
A: Amariguistas? No se el termino en ingles. Pero es que le gusta la parte fea. Como en los periódicos que te demuestran los accidentes. Entonces la gente se asusta ya cuando habla de que te cortan la mano o que te cortan el pie. Y insisto: es prevenible. Entonces, en este sentido yo

creo que si la gente ya ve mas de las consecuencias que la prevención. Por ahí estamos entrando a prevenir.
E: ¿Y por ejemplo cuantas notas en cada cuanto escribe sobre la diabetes? O que tiene que ver o que aborde el tema.
A: Bueno sobre eso, estamos cada semana, mínimo. Específicamente sobre la diabetes si es paseado. Alrededor cada 2 meses. Pero, si temas, como tu dices que la abordan, por ejemplo ahorita estamos mucho con el tema de la insuficiencia renal. Porque es un tema también que se esta afectando muchísimo. Y parte de ello viene de la diabetes. Un porcentaje muy grande.
E: ¿Y con respecto a los morelianos y los diabéticos de aquí. Donde crees que buscan la mayor parte de la gente sobre la diabetes?
A: Pues, la busca ya con su doctor. Pero ya que están enfermos, la verdad. Muy poca persona nos dedicamos a prevenir. Y sabes también que tienes mucho los morelianos. Los remedios caseros.
E: ¿Sí, descríbeme un poco sobre esto?
A: Que tesito de no sé qué. Que para bajar el azúcar un licuado de nopal en la mañana.
E: Que no se debería tomar de hecho.
A: No. Entonces, si son muchos mitos. Y si tenemos muchos, en general los mexicanos también los morelianos a los remedios, somos fieles. En esos somos bien naturales. Pero después de tu agüita te tomas la Coca. Entonces, no sirve de mucho.
E: ¿Y una vez has escrito sobre estos mitos?
A: No, fíjate que no. Yo tengo cubriendo la fuente. Tengo menos de 2 meses.Tengo muy poquito Entonces no he tenido la oportunidad. Y en ese caso de los mitos y como que son mas remontes los editores. En respecto a lo que preguntabas, porque a ellos les gusta mas como te digo, las cifras y lo que dijo el secretario de salud. Si. No les da tanta capo lo que hace la gente. Pero si creo que es importante. Pero como tu dices hacemos cosas que creemos que están bien, pero estamos terminando de acabar.
E: ¿Y donde crees que hay la mejor información que puede conseguir la gente aquí en Morelia?
A: La mejor información…Mira ahorita en IMMS, tiene un programa que se llama "prevenIMMS." Que se trata de informar a la gente para que ellas puedan, pues, prevenir. Entonces creo ellos tienen muy buena información. El IMMS maneja muy bien el Internet. Y tienen otros sitios de salud publica. Que bueno es relativo porque menos del 5% de la cuidad tiene acceso al Internet. En México. Es caro. No se, me imagino que tu pagas Internet para estar comunicado. Y es muy caro no en comparación con los precios de allá. Si porque solo 5% de las personas en México tiene este acceso. Por eso estamos tan desinformados también.
E: ¿Y cuales otros medios crees que pueden servir para difundir la información?
A: Pues, mira yo creo que la tele sirve mucho, somos adictos a la tele, desde chiquitos. Pero también nos gusta ver Las monas de Cambiquin. Y cosas así. no somos tan informativos. Entonces quien sabe si esto se pudiera meterte en algún modo. No sé. La verdad ahí si seria a ponerlos a pensar definitivamente como hacerlo atractivo para toda la población que ve la tele. Porque es así, tendrán techo de cartón, pero tiene dos teles. Es algo paradójico. Entonces yo creo que el mejor medio aquí en México es la televisión. Mas porque también la televisión es lo que llega los actores económicos mas desprotegidos. Entonces pues son los que acceso tienen a prevenir, pues tienen menos acceso a informarse. Creo que seria un gran ayuda.
E: ¿Pues, como crees que la gente ve la diabetes en general? ¿Lo tiene estigmatizado?
A: Sí, creo que sí está estigmatizado. Porque es mala la diabetes, y es una enfermedad que te mata. Y no, no siempre. Bueno cuando ya estas con la diabetes al todo, pues si. Pero antes no, antes se puede curar. Por ejemplo hay mucho diabetes infantil en México. Y las mamas creen

que los niños ya no van a vivir, que se van a morir, que les van a cortar un pie. Y no es así. O sea, si ya te la detectaron desde chiquito, OK, pues aprender vivir con ella, a ponerse su inyección y no hay ningún problema. El problema viene cuando te digo que empiezan con sus "me importas" con sus remedios. Y no les dan los tratamiento adecuados. Que eso también es otra situación. Porque en México, la seguridad social, no es gratis para todos. Yo creo que ahí radica otra parte de que la gente no se trata. Es caro.
E: ¿Aquí, se ve más como una enfermedad del individuo, o más de la cuidad, más de la sociedad, más de la familia?
A: Yo creo que ahorita se ve más como del individuo. Creo que si, se está haciendo, empezando a hacer un poquito de consciencia social de que es una enfermedad de la sociedad. Más por lo que te comento de la obesidad. Ya es que esta empezando a como algo que es de la sociedad. Pero ahorita todavía es "EL tiene diabetes". Y no nos ponemos a ver como estamos comiendo nosotros. Como vivimos. Porque ahorita estamos bien, pero al ratito quien sabe.
E: ¿Y otras creencias que me puedes dar sobre la diabetes?
A: Pues este de que te dije del licuado de nopal con toronja, y no se que. Que te puede dar con un susto. La gente se da cuenta después de un susto porque le sube el azúcar. Pero no es te de la diabetes por un susto. Pero la gente cree mucho esto. Que te da por un susto. Que te baja el azúcar con pan. Es que los mexicanos.
E: Otra cosa, Me entere que hubo una congreso internacional de la diabetes aquí en la cuidad en marzo, fue, ¿no?
A: [indicates that she didn't know]
E: Pues, a ver, ¿conoces otras campañas u otras cosas que han hecho la cuidad para tratar el asunto?
A: Para tratar el asunto, ahorita nada mas son al nivel nacional, lo que es prevenIMMS, y prevenISSTE. Que tienen un enfoque hacia esta enfermedad porque es muy frecuente en la sociedad mexicana.
E: ¿Y luego, pues, va bajando hacia a los pueblos o la cuidad?
A: Exactamente, date cuenta que el ISSTE y el IMMS tiene delegaciones en cada estado. Entonces es lo mismo que viene del estado de México.
E: ¿Pues, bueno otra cosa?
A: Pues, nada, que que bueno que tengas interés por esta tema porque también mucho gente luego se va y no se que tienen la enfermedad. Por ejemplo con lo de la insuficiencia renal. Pero esto es por el estilo de vida que llevan, mas que nada.
E: Pues, muchas gracias.
A: Gracias a tí.

Interview with Arcelia Medina, Journalist at El Sol de Morelia (J3)

E: Bueno, si me puedes decir su nombre, tu profesión, y donde trabajas.
A: Mi nombre Arcelia Lara Medina, me desempeño como reportera del periodo El Sol de Morelia, durante hace 4 años, escribiendo sobre el tema de salud.
E: ¿Y el nivel de educación? Que tienes?
A: Soy egresada de la universidad Vasco de Quiroga, una universidad de particular de aquí de Morelia, en la licenciatura en la ciencia de comunicación
E: ¿Y cuantos años tienes?

A: 24 años
E: ¿Y se nació en Morelia?
A: Sí
E: Y ha vivido aquí toda la vida
A: Si, toda la vida
E: Bueno, OK, vamos a empezar, y me puedes decir lo mas o lo menos que me quieres decir, no las tenemos que seguir exactamente los preguntas. ¿Como periodista, que importante crees que es reportar sobre la diabetes en Morelia? ¿Qué importancia tiene aquí en la ciudad?
A: Yo creo que la diabetes es, digamos que el tema mas importante, o de los mas importantes, por que no esta de menos el tema de la IHV SIDA, no se la hipertensión por ejemplo, pero la de diabetes sumamente importante porque, de acuerdo a los de la secretaria de salud que continuamente reportan, es la enfermedad que más gastos representa a la asociación de la salud pública.
E: Y cuanto es ahora? ¿Más o menos?
A: Mira, el Instituto Mexicano de Seguro Social, que es la institución que mas capta, a la mayor cantidad de pacientes, me parece que el 80% o un poco menos del 80% de su presupuesto se va a atender a ese enfermedades crónicas degenerativas como la diabetes, encabeza la diabetes y la hipertensión arterial. Entonces, esto nos habla de una verdadera problema de salud pública. ¿No? Cómo que es posible que una enfermedad como la diabetes, que a pesar que no tiene cura, todo lo sabemos, pero si esa es una enfermedad que se puede curar con cosas tan básicas como si desde niños nos educan hacer ejercicio, deporte, a comer bien, a comer a tus horas…que mas han dichos los médicos?, no comer comida chatarra, evitar la obesidad. Que te obesa es igual a diabetes, se acabó. Entonces, es un problema que viene desde abajo no? Un problema que tenemos que erradicar desde la educación y no solamente participar los médicos. Ahora el problema ya lo tenemos, y cual es el gasto? El costo es que IMMS esta pagando todo los costos de esta enfermedad que se puede prevenir. Pero además la gente no mide la gravedad del problema de salud pública de la diabetes. ¿Por que? Porque a lo mejor dicen, Ay, este paciente esta enfermo del riñón. Algo, no le funciona los riñones. Mentira. Es que ese paciente este enfermo, que tiene insuficiencia renal porque tiene porque consecuencia de la diabetes. Aquí en México la primera causa de muerte en el país es los infartos al corazón, este, a lo que le llaman enfermedad coronaria los médicos. Pues esa causa, primera causa de muerte, se debe a una complicación de la diabetes. Entonces nos puede hablar de que en México la diabetes pudiera ser la primera causa de muerte. Por esa cantidad de infartos quedan productos de la diabetes. Entonces por es mucho médicos dice es que es realmente la diabetes esta matando tanta gente la diabetes. Por que? Porque muchos vías, la que te digo, por infartos coronarios, esta matando gente también por insuficiencia renal. El IMMS se gasta una cantidad impresionante en pagar los tratamiento para un paciente renal.
E: ¿Y sí, crees que la gente, si te dan cuenta, los morelianos, se dan cuentan de la cantidad de dinero que gasta y la importancia que tiene esta figuro de 80%?
A: Fíjate que he hecho varias notas al respecto, pero aun así, siento que la gente no esta consciente. Y ahí influye otro factor: otro factor es que la gente aquí tiene la cultural muy baja de la lectura. Y entonces aunque yo lo quisiera comunicar mil veces y lo quisiera poner diario y gritárselo a la gente y decir “señores, estamos en un verdadero problema”- si no me leen, que caso tiene? Entonces, ahí si yo me veo limitada. Yo creo los medios electrónicos.
E: ¿Sí, esto te iba a preguntar, cual es mejor medio para transmitir el mensaje?

A: Mira aquí en Morelia, tengo la percepción, de que en Morelia si hay lectores. Una cantidad, es una cuidad con una cultura mas, pues el capital del país que tiene lectores, pero en el interior del estado, la gente es mas humilde, hay mas pobreza, hay mas marginación. Y para que una gente que la vea leyendo periódicos a de ser sumamente raro. Y si lo leen es por que leen la nota roja. Los hechos violentos de Michoacán y eso. Entonces leen esto. Y esto si causa una cierta frustración personal, y que digo, hijo por que no leen de temas de salud, en lugar de leer temas rojos. Pero, bueno, yo creo que la radio, pudiera funcionar perfectamente en el interior del estado.
E: ¿Sí se escucha mucho?
A: Se escucha mucho la radio y yo creo que en la radio si hiciera por lo menos unas capsulas especiales y si pudiera lograr a hacer entender a la gente por este canal. No? Y bueno, nada ello, los programas de salud pública que implementan las autoridades aquí, pues ya se reesfuerza, es un esfuerzo conjunto, entre gobierno, medios de comunicación y la gente. Porque bueno, finalmente nosotros hacemos nuestro esfuerzo y el gobierno, pero si la gente no lo hace, es inútil.
E: ¿Pero, que crees qué medio usa la gente mas para investigar, o los diabéticos mismos u otra gente, para investigar a diabetes?
A: Yo creo que la gente que ya tiene diabetes es la que se interesa. Pero bueno cuando ya tiene el problema. A mi me gustaría que se interesaran los chavos y que dijera bueno es una enfermedad cruel y que pero lo venden a la ligera. Creo que eso solo le da los viejitos. Y no se da cuenta que la diabetes se esta cultivando desde ahorita. Desde que eres niño, no. Les está cultivando. Aquí en Michoacán tenemos un problema severo la obesidad en los niños. Me parece que el secretaria de salud me comento que ocupamos el cuarto lugar al nivel nacional, Michoacán, en cantidad de niños diabéticos. El cuarto lugar nacional. Entonces eso nos habla de que desde niño ya estamos formando diabéticos. Y Entonces que el presupuesto del IMMS ya va a ser insuficiente y vamos a pagar los puestos de todas esas repercusiones. Entonces, estudio el secretaria de salud de aquí, esa problemática e hizo un una propuesta antes del congreso del estado que nos hiciera una ley que prohibiera la venta de comida chatarra en las escuelas. Eso ya se hizo. Ya esta funcionado. Entonces ya no se vende comida en las cooperativas, comida chatarra, me refiero. Ya les vende fruta, les venden agua que esos son mas nutritivas. Pero, cuando salen de la escuela hasta una señora que esta vendiendo churros y le compran churros, entonces dices hijole, por mas esfuerza que hacen las autoridades si tu papa no le dice a su hijo que no debe de comer comida chatarra pues el esfuerzo es inútil. Es inútil. Entonces yo les decía ¿que hacemos, les ponemos bolsinas en toda la cuidad o como? Por que no se dan cuenta de la magnitud del problema. Sin embargo la gente que ya es diabética, lee, se interesa, pero ya es demasiado tarde.
E: ¿Y en donde buscan mas información, en el Internet o con sus doctores?
A: Yo creo que el primer canal que buscan ellos son los médicos, Ya que les detecta todo el problema. Y entonces el médico los empieza a gritar, sabes que la diabetes no tiene cura, y te voy a dar tratamiento durante toda tu vida y así tienes que estar. Entonces esta gente ya solita y lee periódicos solamente si les interesa, lee un articulo, lo lee o escucha y es tal cual.
E: ¿Y se les interesa a tus editores publicar sobre la diabetes?
A; Aquí en periódico?
E: ¿Sí. Aquí en el sol
A: Fíjate que si. Cada que publico una nota, Que casi lo hago de manera periódica. Hace cada cuando de cada año "en Michoacán se registraron tantos casos de diabetes" y las causas. Entonces, si le toman interés incluso le dan llamado en las portadas reportando, en Michoacán tiene tantos caso de diabetes y eso. Entonces también he hecho nota referente a la diabetes en

niños. Porque aquí ya se presenta la diabetes desde este edad también, chiquitos. Entonces He hecho referentes a esto también, si les interesa, como que si hijole, es un problema de verdad. Y yo trato de darles enfoque, no alarmista, si no destacando lo mas importante para que se den cuenta no? Pongo " se dispara el diabetes en los niños". Hay casos desde los 9 años. Pero no lo hago para dar alarmista . Si no también para que se den cuenta del problema.
E: ¿Y cuales aspecto, igual a los editores que a ti, sobre cual aspecto prefiere reportar? Mas de la gente que sufre, la prevención?
A: A ellos les interesa las cifras. Casi siempre las cifras son su …digamos que su principal atracción de ellos.
E: ¿Las estadísticas?
A. Sí, las estadísticas, como en todo el periodismo, Pero específicamente en el las notes de la salud. Si les importa decir que hay tantos casos de diabetes o que se incrementó en tanto numero de diabéticos. Pero yo siempre a pesar de que los primeros párrafos de la nota siempre digo que se reportaron mas casos este año, en los párrafos anteriores o incluso en un contexto, yo intento siempre de abordar y siempre de reiterar que la alimentación, el ejercicio, no comer comida chatarra, aunque parezca disco rayado. Ellos se enfadan que de que yo escriba esto. O a veces cortan la nota, no lo importante es decir que se incrementó y saz le rebanan y ya. Pero yo siempre intento hacer un contextito donde diga que es importante esto, esto, y esto. Y además le abordo mucho cuanto se gasta instituciones en ella. Una vez gana la primera plana porque al director le interesa mucho la nota cuando a mi se me ocurrió preguntarle al delegado del IMMS. Yo le pregunta oiga dr., cuanto se gasta el instituto en curar enfermedades crónicos degenerativas? Y el me dijo nos gastamos el 80% de nuestro presupuesto. Entonces le dije como es posible? De verdad? Me dijo pues si el 80%. Entonces me dijo pues prepárate una especial entrevista, hice una entrevista amplia y se gano la primera plana "GASTA EL IMMS EL 80% DE SU PRESUPUESTO EN ENFEREMEDADES CRONICOS DEGENERATIVAS". E hicimos una tabla de cuanta se gasta en curarle hemodialisis, la diálisis, en amputaciones, es la primera causa de amputaciones- la diabetes. Entonces es un tema le interesa que soportó muy bien. Pero bueno, no todos los días puede estar saliendo esa información. A veces gana la política, luego aquí en México, y en Michoacán en especial, hay temas que se convierten en temas nacional y que gana las primeras planas inevitablemente, no. Y es muy difícil, muy difícil lograr la primera plana de salud, sumamente difícil.
E: ¿Y crees que hay información suficiente en esta cuidad sobre la diabetes, y si la organizaciones, los periódicos o los de salud, que sí dan lo suficiente, o que hace falta mas?
A: Yo creo que si hace falta. Hace falta una coordinación entre medios, gobiernos, y sector educativo. Si esos tres actores de la sociedad se unieran, yo creo que si lograban algo importante. La secretaria de salud difundiendo mas esa información que también le cuesta. Y si no la difunden y si no hacen nada de respecto van a seguir pagando millones de pesos en esa enfermedad. Y nosotros mostrarlos en exposición a colaborar. ¿Como? Bueno un día a la semana se va a publicar en mi periódico un tema de la diabetes. Es que el tema de diabetes es tan amplio que no lo puedes agotar en una simple nota. O sea hoy bien puedo hablar de cuando se detecto el primer caso de diabetes, cuales son los origines, o sea puedes hablar infinidad: DM, tipo I, tipo II, en los niños en adultos, amputaciones, ceguera. No se acaba. Es un tema inagotable, inagotable. Investigaciones recientes sobre la diabetes. Y el sector educativo de su parte, yo creo pues abrir un espacio a la semana o yo que sé con los niños y hablarles de la enfermedad. No tiene nada de malo. Ahora los niños son sumamente inteligente. Pueden comprender muy bien y

decirles, es si comes comida chatarra desde ahorita. Entonces yo creo que esos tres esfuerzos serian ideales. Pero hace falta mucho. Mucho.
E: ¿Y cuales organizaciones te parece que sí están tratando a difundir la información a la gente o a organizaciones como ustedes?
A: Yo creo que, me acuerdo que hay una organización de médicos que trata específicamente del tema de la diabetes, abordan el tema de la diabetes. Pero luego siento que son reuniones que se quedan en la mesa. Y que es difícil aterrizarla socialmente y llevar al cabo ya un proyecto en concreto. Abordan quizá bien, pero a la hora, a lo practico no se ve nada. En el seguro social, las doce investigaciones que tienen los médicos de ahí, todas están enfocadas en la diabetes. O sea las únicas doce TODAS tiene que ver con la diabetes. Uno es el manejo de tal medicamento para la diabetes. Cómo funcionaria tal medicamento para la diabetes. Todas tiene que ver con la diabetes. Y le decía a un médico hace bien poquito "oiga pero ya se pone en practica las investigaciones, que no se quedan en el laboratorio". Me dice " mira, es difícil que una investigación, y sobre todo del tema la diabetes ya se vaya a la practica. Nosotros lo estudiamos, y luego compartimos esta información con mas investigadores. Y esos agarran de ese tema y lo enriquecen hasta que se logran algo en concreto y se aterriza. Una serie de, no sé, de investigaciones y luego que otro porte y que quien sabe qué. El chiste es que esos son investigaciones muy amplias que quien sabe cuando vaya a llegar a la sociedad. Pero sí, se investiga.
E: Y por ejemplo este, tenían el congreso internacional de la DM, hace un año, ¿y esto cómo impactó a la ciudad? Pues con respecto a la investigación o de teoría y de practica, y a la gente que sufre de la diabetes. ¿Se dieron cuenta?
A: No, hazte cuenta, que cuando yo dije, va a haber un congreso internacional de la diabetes, órale que padre. pero hazte cuenta como te comente antes.
E: ¿Fue la primera vez?
A: Si. Se quedó en un evento dirigido en una población muy reducida. Hazte cuenta solo acudieron médicos, autoridades de salud, y periodistas. Pues, si los involucrados, no pueden meter ahí toda la sociedad, que padre que todos escucharan todo esos ponencias. Pero bueno, si tiene un bueno objetivo, porque prepararon los médicos de aquí, y escucharon los puntos de vistas de internacionales. Y se dieron cuenta del panorama. Y luego eso, pues en sus propios consultorios o los autoridades de salud tomaron medidas al respecto. ¿No? Pero bueno, nosotros nos limitados a escribir la nota de que Morelia iba a tener y que se iban a tratar tal cual tema y ya. Igual la gente dice "que padre va a haber un congreso de diabetes", pues ya.
E: Tampoco estaba invitada.
A: No, tampoco estaba invitada. Entonces, es un tema bien difícil y para llegar para que la gente lo entienda es muy difícil. Somos muchos como para decirles "reacciona, reacciona!". Pero bueno a mi me parece que a pesar de todo fue un importante esfuerzo donde se trataba de temas sumamente interesantes. Aportaciones de investigadores como los que te decía. Decía órale se está investigando, se esta aportando algo para la enfermedad que algún día esperemos que tenga cura, veranada? Cada quien hace sus esfuerzo en la trinchera. Cada uno hace su esfuerzo.
E: ¿Y la Universidad? Ví que tiene un programa de licenciatura de nutrición.
A: La que tiene licenciatura en nutrición es la universidad vasco de Quiroga. Y ellos han hecho conferencias, referentes a la diabetes. Es una carrera nueva aquí en el estado. Pero ellos han enfocado precisamente en la importancia de la nutrición de la población para que no haya diabetes. Y si han hecho ponencias referentes a las esquemas de nutrición, y todo para reducir la

diabetes. Están investigando que alimentos sí, que no, que el azúcar, que el otro. Pero si ellos se han interesado bastante.
E: Un poco mas sobre los que sufren de la diabetes. ¿Te parece que en cualquier manera están estigmatizados? ¿O si la gente los ven como diferente?
A: Yo creo que no. Creo que los diabéticos son los que menos sufren discriminación. Creo que como es una enfermedad crónico degenerativa que no se refleja en tu aspecto físico, al menos que ya tengas insuficiencia renal, pues si te ve un poco. Vive mucha gente diabética. Pero como esta bien controlado con medicamento nadie se da cuenta que tiene diabetes, solamente el. Luego, hay algunos especialista que si decían que la diabetes le causaba depresión, dicen "soy diabético, me voy a morir?, no tengo cura, voy a morir en 10 años". Pero creo que aquí en Michoacán tiene mas discriminación la gente con VIH SIDA.
E: ¿Pero esto no es al nivel de la diabetes, verdad?
A: Para nada.
E: ¿Y hay algunas creencias o algo especifico que creen los diabéticos sobre la enfermedad?
A: Eso es sumamente importante, y eso hay que escribirlo mil veces. Porque la gente diabética, sobre todo en el interior del estado cree que con hierbitas, que con el de quien sabe qué, que con la rama de no sé qué. Y aquí en Michoacán hay mucha cultura de la medicina tradicional, que le llamamos. Entonces ahí hay muchos médicos tradicionales que tu vas y "que le duele sra.?". "Fíjese que me duele el riñón." Mira, les tocó, colocó, se le ponen esta hierba, le echa ese. Y la gente confía planamente en que se va a curar con eso. Incluso hay medicamentos que aparecen que dicen que curan la diabetes. Y creen que cura la diabetes. Te puedo asegurar que hay mucha gente que no sabe que la diabetes no tiene cura. Entonces, creen ellos que se cura. En ese tema si hay que escribirlo mucho, por que si no. Creen que se cura. Y la diabetes se puede controlar, con medicamento, no se cura con hierbas o quien sabe que.
E: ¿Crees que la mayor parte de la gente sí va al médicos, sí toma medicamento, sí va a un tratamiento normal, o que la mayor parte mas bien prefiere los remedios naturales?
A: Fíjate que un investigador de un hospital importante de aquí de Morelia, comentaba, no recuerdo bien la cifra, pero creo que de cada 8 diabéticos 1 no sabe que tiene diabetes. O sea una cantidad importante, no sabe que tiene diabetes. ¿Por qué? Por que nunca ha ido al médico, si le duele algo toma una pastilla que cura el dolor instando, o cuestiones así. Yo creo que la gente que tiene diabetes, pudiéramos decir que hay una cantidad que va al médico, porque tan solo en el seguro social, ahí tienen una lista de 56 mil diabéticos en Michoacán. Solo en el seguro social. Habrá que sumar los de la secretaria de salud, y habrá que sumarles los que se atienden en hospitales particulares. Aunque la hipertensión arterial, ya superó a la diabetes. Por lo menos en el Instituto de seguro social.
E: Y muchas veces una persona sufre de los dos.
A: Casi siempre, van ligadas. Hipertensión y diabetes. Como te digo la diabetes, se manifiesta de diferentes formas. En hipertensión, pie diabético. Entonces seguramente son muchos no? Aquí en Michoacán 4.5 millones de habitantes. 56 mil solo atendiéndose ahí. Bueno. Sumando los demás pues, seguramente es alta.
E: Sobre todo lo que me has comentado es que es una como cosa muy normal, pero sobre lo que no habla la gente.
A: Yo creo que también debe de influir que la gente anda en su vida, su trabajo, sigue haciendo su vida normal, no hace cuenta. Y que luego, como que las enfermedades pasan al segundo termino les importan mas el desarrollo económico, sacrificando su salud. Sabemos de mucha gente que se esclaviza en el trabajo. Pues "quien sabe si tengo diabetes, ya cuando sea viejo me

daré cuenta, me trataré". Pero yo siento que sí vivimos de un ritmo de vida muy rápido, me importa tener un carro, me importa tener una casa, me importa tener dinero, mi negocio, mis hijos, la escuela, al ultimo veré si tengo diabetes o no tengo. Entonces, esa decide la gente. Ya cuando les empieza a doler algo o van al médico, pues hacen al diagnóstico como dicen los doctores, ya es sumamente tarde. Y le dicen, sabe que sra. Tiene diabetes tipo II y es irreversible.
E: ¿Y cuando se enteran, crees que es una cosa individual o mas bien de familia?
A: Yo creo que si se involucra la familia. Cuando llega un diabético a la familia, la demás se empieza a interesar por el tema. Sobre todo porque yo se si algunos de mis familiares tienen diabetes seguramente voy a tener. Y tu sabes que es hereditario. El factor hereditario es la principal por la que aparece diabetes. Creo que sí se interesan pero ya tomando de ejemplo que alguien se afectó y sus riñones no funcionaron etc. Aquí en Michoacán existe la mayoría de los que requieren un transplante de riñones, la mayoría requiere un transplante precisamente porque ya fueron diabéticos. Entonces fíjate, desde cuando pudiéramos prevenir que alguien necesitara un riñón o que si estuviera dializando o hemodiálisis o todas esas cosas que son bien caras. Entonces ya cuando alguien quiere trasplantar, espérate ahí a ver si alguien te da un riñón. Luego si no hay muerte cerebrales que es cuando se puede donar, pues no, no tienes. Entonces luego la familia se compadecen. Aquí sí, hay una cultura de que les done su familiar, su riñón. Pero esto también es consecuencia de la diabetes. Pero que necesidad hay de que yo viva con uno solo riñón cuando a quien a que se le dono pudo haber prevenido que le diera diabetes. Si desde niño comiera bien, hiciera ejercicio o sea cosas tan básicas. Pero ya cuando llegan ya están enfermos, y requieren un riñón. Y luego no hay riñones. Y aquí hay por lo menos unos doscientas personas esperando un riñón en el seguro social. 200 en la secretaria de salud. Antes era doscientas personas esperando un riñón. Y quien hace los doctores? O sea por mas que quieren no los pueden operar. Por que? Si no tengo riñón que te pongo? Y si no hay donantes, pues mucho gusto. Y como es crónica se van enfermando y llega el momento en que se muere. La lista de espera es enorme. Se tiene que ir a Guadalajara, se tiene que ir a México. Se ponen en una lista de CENATRA. Este centro les tengo en Guadalajara. Este centro tiene una lista impresionante esperando un riñón a causa de la diabetes:
E: ¿Y no ayuda la familia con respecto a hacer mas ejercicio, ni a preparar una cena más sana?
A: No. ¿Y sabes que influye mucho? La pobreza. Porque aquí en el interior del estado, Michoacán es uno de los estados mas pobres del país. Hay pobreza urbana aquí en Morelia. Sí, lo hay. No lo toma mucha en cuenta, pero sí hay. Casi siempre ponen mas atención las autoridades en la pobreza extrema, más que en las zonas periféricas del estado. Entonces como que hay tanta pobreza en el interior del estado, viven algunos de las cosechas. En Michoacán no hay industria, entonces no hay empleo. Y lo único que se ofrecía aquí es servicios, comercio, y la agricultura. No? Muy poca que este en reserva en el campo, pero el poco que se produce de eso viven. Entonces si tu eres pobre y si puedes comer frijoles y mañana puedes comer chicharrón. Pues eso te va la diabetes mas temprano en general. Pues, aunque ellos quieran alimentarse bien, no pueden porque la económica es un factor que también influye. En la pobreza en la diabetes y en la aparición de esta. Hay un desnutrición severa en los niños. Hay incluso un programa, que se llama programa CRECER, que les dan leche a los niños, leche fortificada. En que están dentro de esta esquema la gente mas pobre del estado. A ellos si les dan leche a los niños. Pero aun así sigue siendo esa limitante económica que no les permite alimentarse bien. Y la gente que tiene posibilidades económicas, es la otra parte de la cara. Pudiéramos hablar de una familia de clase alta aquí en Morelia. Que bien tiene un salario, no alta, pero si lo suficiente para poder pagar un alimento bien en la casa. Luego prefieren comer una hamburguesa en Burger King, rápido, o

pedir una torta en el trabajo. Esas serias de cosas, que parecen a la ligera y que van de diario y que la misma vida que te llevas, entonces no te das cuenta. Y ya ve de pronto que tiene diabetes, porque? Por todo lo que comiste, por el mismo estilo de vida que llevaste, porque no hiciste ejercicio. y luego que ya están ciegos y no saben porque que ciegos, por la diabetes. Y porque les duele un pie? Porque ya tiene pie diabético. O sea es un tema bien complicado, que influye como te digo el factor económico, la desidia, el desorden de tu vida. Y luego aquí en México las frutas son muy baratas si las comparas con otros países. O sea si te vas a Europa y un plátano, aquí cuanto te cuesta un kilo? 15, 10 pesos. Allá te cuesta mucho. Y aquí la gente prefiere comprar un kilo de chicharrón de puerco a comprar un plátano. O sea la verdura o la fruta es muy barata. Y no hay pretexto para decir que no tienes dinero para comprar. Por lo menos una familia de clase media. No tiene pretexto para decir que no tiene para comprar naranja, y hacer jugo de naranja y comer en la mañana una sopa de verdura. Etc. Pero bueno los estilos de vida han cambiado mucho. La gente tampoco pueden ir a su casa y decir, espera, me voy a comer mi ración de lechuga y mi. Si alcanzo como y voy a mi casa, y si no, pido una torta, porque tengo una reunión que el jefe. Y si no, me corren. Es bien complicado. Yo creo que tenemos que acostumbrarnos a vivir con la diabetes. Creo que sí. Y va a ser bien difícil que desaparezca la enfermedad por todos estos factores que te digo. Ojala, mucho hicieran el esfuerzo de decir, bueno voy a ser el intento de hacer el ejercicio o comer bien. Yo mismo me he preguntado del hecho, bueno yo escribo tanto, y no soy factor de ejemplo. Entonces dije, no si tengo que ser factor de ejemplo. Y así me decían mis maestros, es que si escribes sobre estas cosas tienes que ser factor de ejemplo. Y yo, Sí es cierto. Entonces si me meto en el gimnasio. A veces se me hace tarde pero le corro y voy y hago ejercicios. Y a veces me caigo y se me antojo unos como uno churros o una torta. Caes en el juego de todos, de todas maneras. Pero bueno, lo menos que lo puedas evitar es considerable. Sobre todo yo tengo tendencia a ser diabética porque mi familia es diabética. Pues, digo no yo tengo mas posibilidades que otras personas así que me tengo que cuidarme mas que las otras personas.

E: Una pregunta mas, sobre el acceso a las organizaciones de salud, ¿sí tiene acceso la gente?

A: Yo creo que está muy cerrada la posibilidad de que la gente como uno muy corriente acceder a una organización de diabéticos. Por lo menos de tipos oficial. Yo que si se, hay muchos organizaciones de diabéticos que han hecho ellos mismo. Aquí en la secretaria de salud existe un club de diabéticos. Hay varios clubs, hay club de la embarazada, club de que se que. Pero son muy importantes, esos clubs, porque ahí, si se aterriza las ideas. Hay un club de diabéticos que comparten experiencias. 'Y ahora tomo mi presión como es?' "y ahora que comes, antes que comías?" " Y no te dieron tal medicamento?" "Y no te mareaste?" "Yo si me maree." Entonces esos clubs han permanecido, no se cuanto tiempo tiene pero no tiene mucho, al menos 5 años, mas de 5 años no tiene. Y ahí, se intentado hacer un esfuerzo por parte de las autoridades porque ellos mismos intercambien ideas. Y el seguro social por otra parte, tienen esos clubs, en donde ya esta gente ya grande, jubilados. Gente que ya solamente recibe su pensión. Por haber trabajado tantos años y reciben como $M1000 mensuales. Todas las mañanas puedes ver, incluso hoy, los ví en la mañana, ahora que fui al seguro social. Hacen clubs para hacer ejercicio, pero todos son mayores. Hacen ejercicio. Pero como te digo, ya para que? O sea no esta mal que hagan ejercicio. porque les sirve, son diabéticos y si se ejercita y se controlan con medicamento obviamente su vida se va a prolongar y su estabilidad hacer mejor. Pero ya para que? O sea ya para que cuando yo mama, para que las que tiene niños, yo les llevo desde chiquito a la natación, y desde chiquito que yo lo encarrilo hacia esta ruta a la prevención, por decirlo de alguna

manera. Pero no hay esa cultura. Influye factores. No hay tiempo. A que hora te llevo, quien te llevo? Es bien complicado, hasta que me da ganas de llorar.

Interview with Dr. Fracnciso Rodriguez Ortiz, M.D. (CEYAMED.) (H1)

O: Francisco Rodriguez Ortiz, médico especialista en investigación biomédica
E: ¿Y es usted de Morelia?
O: De Morelia
E: Y me puede decir lo que se hace en CEYMED
O: OK, ¿que se hace? Se da consulta externa, básicamente de diabetes, a mi novecidad por provisión de diabetes. La consulta implica hacer una revisión completa y abordar cinco aspectos básicos: El tratamiento, alimentación saludable, obviamente todo lo que es el químico antecedentes, el que es el ejercicio físico, toma de medicamentos y medición de la glucosa, y educación. Estos son los cinco aspectos de se toca en cualquier consulta.
E: Pues, a mi por la mayor parte lo que me interesa como consigue la información sobre la diabetes la gente aquí en Morelia.
O: ¿Con respecto a este centro específicamente?
E: Sí.
O: O son por el directorio telefónico o bien por recomendación. Un paciente recomienda otro de esa forma se logra el contacto. Hemos implementado las compañas como son tele, radio, periódicos, pero no funcionan. Lo que funciona mejor es el directorio telefónico y la recomendación de persona a persona.
E: ¿Y sí, cree que hay suficiente información en Morelia sobre la diabetes?
O: Sí, debe de haber. No todo el mundo la aborda como la abordamos aquí en el centro. La mayor parte de los médicos la abordan de una manera muy superficial, rápido y a ellos les importa números de pacientes y no calidad. Aquí es diferente. Una consulta de primera vez nos lleva alrededor de una hora y media, dos horas. Para abordar los aspectos básicos.
E: Y me parece que sí, enfatiza mucho la educación, y cualquier aspecto en especifico.
O: La educación es clave. Si no hay educación, no hay adherencia total. Esto es lo que estamos reforzando en cada consulta-la educación. A parte tenemos cursos damos un curso en como convivir con la diabetes.
E: Y puede describir un poco los cursos.
O: El curso implica, la pusimos en cuatro sesiones, una cada semana. La primera es los aspectos generales de la diabetes, cuales son las causa, como son los síntomas. Luego el siguiente modulo es la alimentación, el tercero es ejercicio, y el cuarto complicaciones y tratamiento de la diabetes, básicamente lo que se llama información de sobre vivencia.
E: ¿Y mas o menos cuantos clientes tiene en los cursos?
O: Es muy variable, entre cuatro y diez por curso.
E: ¿Y en total? ¿Por año, cuanto?
O: Es muy variable, la gente en nuestro medio, igual en todas partes la gente no están acostumbrado en la educación en la salud. Entonces es muy variable. A veces tenemos seis cursos al años a veces cuatro. No hemos pasado de seis.
E: ¿En cual aspecto la gente se interesa más? ¿La educación, tratamiento, la prevención?

O: Otra vez, como no hay una educación de salud. La gente no acudía prevenir. Digamos un 5% de las personas de CEYAMED acudía para prevención y la otra 95% es porque ya tienen complicaciones. Desafortunadamente.
E: ¿Y con respecto a las noticias locales u otros organizaciones cómo tratan el asunto de la diabetes?
O: Hay periódicos, los mayores circulación aquí en Michoacán son La Voz de Michoacán, Provincia, y La Jornada. De estos la Voz tiene una serie, una sección, ya fija sobre la salud. Así que cada 8 días aborda diferente tópico. Consultan con especialistas. Nosotros hemos tenido la oportunidad de participar con ellos. Este ultimo año ha disminuido un poco la participación. Pero cada año lo hacemos tres o cuatro veces con ellos. Abordamos los aspectos básicos de la diabetes. Y las complicaciones que implique: el cíclico metabólico, distemidemica, obesidad, etc.
E: ¿Y cree que lo abordan de manera profunda?
O: Lo abordamos profunda pero a la vez, en un lenguaje sencilla, lo quitamos el lenguaje medico, y nos damos un poquito de lenguaje coloquial.
E: Yo me enteré que hubo el congreso de la DM.
O: Cada año hay un congreso, hay un grupo que sale de la institución, y ellos hacen un congreso.
E: ¿Y a usted como cree que impacta la ciudad desde los médicos hasta la gente que sufre de la diabetes?
O: No hay mucho repercusión de los pacientes. La mayor parte de la audiencia son estudiantes de la facultad de medicina, y la otra es médicos generales, y otros especialistas. Así que el impacto que yo quisiera no lo tiene sobre la población en general.
E: ¿Y por ejemplo para tener mas impacto, qué podrían hacer, con respecto a este congreso, o a otra cosa?
O: Muchas de cosas corresponden al estado. Entonces el gobierno de vez en cuando empieza con sus spots en el radio, sobre prevención de diabetes, complicaciones, igual con la obesidad. Y de esa forma es la que se puede llegar un poquito mas a la población. Nosotros en un tiempo lo estuvimos haciendo, pero es costable. Definitivamente el que tiene el dinero es el gobierno.
E: ¿Y cree sobre todo que hay organizaciones suficientes que trata de la diabetes, en medicas?
O: Sí las hay. Pero no se si sea las instituciones necesaria. Aquí había una asociación de la diabetes, pero se dedicaron mas a la mas al aspecto comercial, de productos para las personas con diabetes que a la educación. Yo participo en un grupo nacional de diabetes, se llama grupo de estudios de diabetes, cada año tenemos una reunión. Este año nos toca en Guadalajara en agosto. Y a través de esta asociación, organizamos cursos para estudiantes, para médicos, y ocasionalmente para el paciente. El paciente es muy difícil en nuestro medio. Muy difícil. Solo vienen cuando ya están malos.
E: Y con respecto a la gente que tiene la diabetes ¿están estigmatizados en alguna manera?
O: No, no, no. No hay discriminación contra un paciente con la diabetes. Muchos ocultan su enfermedad. Porque, bueno es parte de la negación. Y algunos se quedan toda la vida en la negación. Pero la mayoría aceptan la diabetes. Y si llevan un buen control con el alimentación, ejercicio y medicamento, como ellos dicen ni parece que tengan diabetes. Pero depende del grado de aceptación de la enfermedad.
E: ¿Y cree que las organizaciones debería de dedicarse mas al tratamiento o la prevención?
O: Bueno la medicina debe ser prevenir, en todas partes. Desafortunadamente no se hace. Porque dinero se dedica a otras cosas, se los roban, o lo metan a la política. Por ejemplo, acaba de pasar las elecciones. Decían ahí que nos bombardean con creo que 38 millones de spots, los anticipatorios de elecciones. Si esos 38 millones de spots metiera a la salud, seria estupendo. Lo

que se dice aquí cuando platicaba con unos políticos, cuando no es época de elecciones el gobierno tiene un excelente de dinero, digamos. Y es cuando empieza a promocionar la salud. Y en las campañas políticas u otra cosa políticas, ese dinero se lo dedican a la política así que se lo pierde. Pero si ese dinero fuera invertido constantemente en salud, seria estupendo. Nosotros notamos inclusivo cuando esas compañas comienzan en el radio, aumenta la fluencia de pacientes.
E: ¿Y esto pasa cada año?
O: Digamos 2 veces al año mas o menos el gobierno prende campañas de prevención de obesidad y de la diabetes. Y aumentan los clientes.
E: ¿Y cuales son algunos creencias que tiene la gente sobre la diabetes?
O: Bueno, pues hay muchos mitos todavía que se maneja. Como es que la insulina los deja ciego. Las otras pues recuerdan mucho a la medicina alternativa. Lo que nosotros aconsejamos es, no está prohibida, pero siempre que no abandonen el tratamiento médico. Y todas las opciones que tengan de medicina alternativa están bienvenidas.
E: ¿Y seria mas bien un problema individual o de la sociedad o de familia?
O: La diabetes se considera hoy no un problema individual, sino un problema de salud publica.
E: ¿Con respecto a la gente que tiene la diabetes, o el gobierno? ¿O a quién?
O: Con respecto a la salud general de la población. ¿Sí? Y no es nada mas al nivel local. Es al nivel mundial. El numero de pacientes con diabetes se esta incrementándose terriblemente. Y parte de ello es la obesidad encadenante. Entonces las campañas el original enfocadas en la obesidad, y de esa forma evitar la diabetes o la prediabetes.
E: ¿Y a usted que le parecen que los que tienen diabetes deben el hecho de que tienen la diabetes: al genéticos, la comida, o al no hacer ejercicio?
O: Pues, la diabetes es poligénica o multigénica. A parte multifactorial. En la diabetes tipo I hay otras factores de susceptibilidad. Pero definitivamente es el estilo de vida lo que les van a desarrollarlo. En la diabetes tipo 2 hay muchos genes, y bueno es quizás mas determinante el estilo de vida. El exceso de la comida, comida rica en carbohidratos, y en grasa y la falta de ejercicio.
E: Y los diabéticos ponen énfasis en un aspecto u otro? “Porque mi mama es diabético voy a ser diabético” o “porque no como bien voy a ser diabético”?
O: Alguna gente piensa, que claro por tener la genética tiene riesgo, y poca emprende alguna acción. Medirse periódicamente su glucosa, mantener su peso. Pero la mayoría no se hacen caso de esto y les sale la diabetes.
E: ¿Pero sí, sobre toda la gente que tienen diabetes se creen capables de controlar la enfermedad?
O:…El problema básico aquí, sobre todo con la diabetes tipo2 es del cambiarle el estilo de vida. Son gente que han tenido mínimo 30-40 años con un estilo de vida o con malos hábitos de sedentarismo. Y eso es lo que cuesta un poquito de trabajo. Por eso es la insistencia de la educación en diabetes. Porque si los vamos a educar le vamos a dar tratamiento para que ellos de pongan bien.
E: ¿Y desde su punto de vista apoyan bien los parientes a los que sufren de la enfermedad?
O: Si algo que estamos cambiando es eso. bueno yo manejo diabetes desde 1976, y el hospital nacional de México, y luego vine para acá. En aquel entonces, se asumía mucho que responsabilidad era básicamente del paciente. Ahora todo esto cambio. Pues la responsabilidad es compartida. Y hay que buscar apoya a la familia. No puede dejar solo al paciente. Y algo muy común es por ejemplo que todo el mundo esta comiendo una comida no saludable y al paciente con sus verduras, no, no. Todo eso tiene que cambiar. Los mismos hábitos alimentación que se le

inculpan en el paciente y de ejercicios, que se hace de ejercicios de la familia. Y también la otra cosa que buscamos es que la familia no se convierte en policía. ¿Si? Porque luego están: "No comas esto". No, no, no. El paciente tiene su responsabilidad. Y ellos van a ayudar preparando la comida saludable. Y haciendo lo mejor posible el paciente con diabetes. Pero no se les permite convertirse en policías. Porque lejos de ayudar para que no generar conflicto.
E: ¿Y sí, ve esto bastante con sus pacientes?.
O: Al principio sí. Pero ya una vez que ingresan al centro va a empezar a cambiar todos estos conductos.

Interview with Dr. Guadelupe Partida Hernandez, Ph.D., M.A. (CEYAMED.) (H2)

E: Bueno, si me puede decir su nombre, y su profesión.
P: Me llamo Guadalupe Partida Hernández, mi profesión es química farmacéutica bióloga. Pero tengo varios grados académicos.
E: ¿Por ejemplo?
P: Soy especialista en investigación biomédica en diabetes, tengo una maestría un biología experimental, otra maestría en bioquímica, y soy actualmente Dra. En ciencias biológicas, mi campo de acción es diabetes.
E: ¿Y es usted de Morelia?
P: No, soy horizaba, Veracruz.
E: ¿Y cuanto tiempo lleva aquí en Morelia?
P: En Morelia 14 Años.
E: Ya me hablo un poco sobre lo que se hace aquí en CEYAMED, pero según su punto de vista ¿cual es la información que enfatiza lo mas con respecto la gente que tiene diabetes aquí en la organización?
P: Nuestra preocupación primero que nada, es que la gente que recurre al centro es porque viene ya tiene algún síntoma. A pesar de que el centro es un centro de atención, y que tiene una finalidad a la prevención, los últimos 5 años nos hemos dedicados mas bien a los aspectos diagnósticos de diabetes. Aunque damos platicas sobre que es la diabetes, medidas preventivas, algunas cosas alrededor de esto. Pero particularmente la gente llega aquí ya con algún síntoma. Es la razón por la que nos avocamos ya a la terapéutica, enfocado mas bien primero a la dieta y ejercicio. Y posteriormente a las cuestiones farmacologías.
E: ¿Y cree que hay organizaciones suficientes que enfatiza la prevención?
P: No, aparte, pertenecemos a un grupo al nivel nacional y representamos el estado de Michoacán. El Dr. Es subdirector, y yo soy represéntate del estado de Michoacán. Nos ha costado mucho trabajo la comunicación con los autoridades de salud en el estado. Porque no necesariamente se acercan a las personas expertas, sino sus conocidos y lamentablemente no se hacen difusión, y no sé si es una buena difusión de la prevención. Sin embargo al nivel de docencia, en la facultad de medicina, doy platicas sobre lo que es la prevención en la población mexicana por el auto riesgo que tenemos. Y que va desde determinar el sobre peso, la obesidad y posteriormente una cosa de diabetes. Pero no hay suficientes asociaciones.
E: ¿Y a quién cree que es la responsabilidad empezar con las charlas sobre la prevención? ¿Organizaciones como ustedes? ¿Mas bien las escuelas? ¿Otro?
P: Aunque nosotros hemos tomado este papel yo creo que es desde las escuelas. Hemos podido incidir como profesores, al menos yo donde estoy, a nivel de modificaciones en el plan curricular de la licenciatura en medicina, la licenciatura en enfermería, y sobre todo en la maestría, ahorita

estoy en la maestría en la ciencia de la salud. Una de las cosas donde más presionamos nosotros es en, eso aspecto de prevención, en donde podemos incidir. Generalmente las personas que trabajan en la universidad como investigadores dicen que necesita laboratorios, hacer muchas cosas. Y les nosotros decimos que no es eso, que lo que se necesita es educación. Da platicas al respecto de la educación. A la modificación a los cambios del estilo de vida. Y por eso creo que si es labor desde la docencia para uno como profesor, como responsable de una empresa que habla de la salud y por otra parte creo que es a nivel de nuestros hogares. Y seguir buscando formas para incidir en autoridad que tiene a su cargo esos aspectos de salud para que ellos incidan desde arriba hacia las escuelas. Para que desde el kinder o la primaria se haga algo.
E: ¿Y por qué cree que no hacen esto?
P: Pues yo creo que es por ignorancia.
E: ¿Por parte de quién?
P: De las autoridades de algunas escuelas. Nosotros hemos visitado, nos invitan luego, nos hace una conferencia a ver lo que hacen. Y no se imaginen de que vamos a hablar hasta que llegamos y empezamos a decir "vamos a hacer algo practico". Vamos a hacer un taller. Empezamos por decir, aquí tengo mi bascula, aquí esta mi cinta métrica, voy a determinar índice de masa corporal, vamos a ver cuantos de nosotros no estamos en un peso saludable. Entonces la gente empieza a tomar conciencia, porque tengo la directora, esta la profesora que me invitó, están los padres de familia, pero cuando les involucro llega un momento que si les impresiona y empiezan a decir, "pues, es que no sabíamos esto," "creíamos que esto era saludable". Cosas así de vienen con los mitos.
E: ¿Y tiene mucha oportunidad para hacer cosas así, practicas?
P: No, casi no, fíjese. Porque como trabajo en la universidad, hago investigación, estoy aquí, pues pienso que no. Pero en años pasados en la cuidad de México formamos un grupo y había de varios profesiones, era interdisciplinaria. Sicólogos, médicos, internistas, pediatras, químicos, entonces empezamos a incidir. Entonces pienso que aquí en Morelia nos ha faltado un cursional otra vez, con diferentes profesionistas, que tiene el misma inquietud de nosotros de incidir en esos aspectos de salud, sin que salgamos en la foto. De la política michoacana.
E: Antes empezó a hablar sobre los mitos, pues si me puede describir un poco sobre lo que quería decir con esos.
P: OK, como Mexicanos, estar sobrepesaditos y gorditos es el aspecto en que estamos saludables. Luego, Y si eres mexicana, a esta determinada edad por la menopausia o lo que tú quieras, por problemas sicológicas de la relación de pareja porque entraron en la menopausia. Empiezan a descuidar su presencia física y tienden a hacer gorditas. Cuando les pregunta y tu porque estas gorda. "Dice porque es natural. Yo ya tuve mis hijos y están grandes. Ya no hay quien viene a ver me, y entonces que importancia tiene? Como no tengo muchas cosas que hacer, dado que mis hijos ya crecieron, entonces me dedico a comer." Entonces observamos que hay como un desconocimiento de lo que es la salud. Pero la salud integral. Que va desde la mente, en medio, la figura. Con la practica de hacer algo, aunque tus hijos se vayan y hacer algo aunque el señor esta ocupado en su jubilación, algunos aspectos que ya no se ha vuelto a ser su pareja. Pues yo creo que, por que yo he dado algunas platicas también con respecto de reencuentro con uno mismo, después de determinadas etapas: cuando los hijos son adolescentes, cuando los hijos se van a estudiar a la universidad, cuando los hijos se casan, cuando ya nos quedamos otra vez con este extraño quien es nuestro esposo. Y que buscamos reconciliar ciertas actividades que no habíamos hecho. Retomando a nuestro juventud. Como es hacer un deporte común, volverse a cuidar del físico, procurarse físicamente en cuanto a arreglarse. Y pensaba en eso del mito. Y yo

como estoy vieja, pienso que esto es una pregunta mental. Y que nadie es viejo hasta que uno lo piensa. Entonces cree que estamos incidir culturalmente. Por ejemplo he vuelto a ver gente de tercer edad inglesa, delgada, cuidadosa de su presencia física. así ya no tengan pareja por que ya sabe que se muere primero los hombres. Pero es parte del mito ¿no? Y tiene que ver mucho que ver con la autoestima. El hecho de bueno, ya no le sirvo a alguien. Cuando el mas importante es servirse a un mismo. Un mito mexicano para mi también, el hecho de que si tu tienes un autoestima saludable en donde reconoces que eres importante para ti mismo, y los demás no incide con ese impacto sino como uno esta fuera de contexto, y ya si que tengas tacha. Porque existe una población mayor con autoestima que no maneja l aspecto de que el salud viene desde la aceptación propia. Y si ya me veo a mi misma ya gorda y estoy diciendo que estoy gorda, pues yo empiezo por decir y ¿qué?, así te quieres quedar. Entonces eso es un mito para mi él que nos encajone, hombres y mujeres, que por determinada edad, primera por etapas de tu vida, oiga no, ya tienes que dejar de ver tu persona, dejar de ver tu crecimiento personal, y la salud, pues si te enfermas es natural, pues que esperas si ya estas viejo? Cuando yo creo que un reflejo y la buena nutrición y los buenos hábitos le dejan saludable. Yo ya corrí 56 años, y digo a dios Gracias no soy diabética. No soy hipertensa. Y estoy en esa idea desde hace mucho años sé que puedo entrar en ese estadística. Y que por cada año que transcurro me felicito de no entrar en ella. Entonces eso se hace que mantiene el autoestima.

E: ¿En Morelia donde le parece que la gente busca la información sobre la diabetes?

P: Cuando aquí en Morelia, se boletinan, reuniones y congresos que específicamente dicen la palabra “diabetes” usted verá entre la recepción, que solamente no tratan de inscribirse médicos, enfermeras o sectores de salud, hay gente que son padres de familia, hay gente que tiene diabetes, que lo hace por y “bueno que hay actualmente?”. Con una esperanza de se me ira a quitar. O que “medicamento milagroso están ahorita investigando”. Y voy más allá, “me gustaría ser conejillo de india de un investigador de estos con esperanza que me quite la diabetes”. Entonces, yo en Morelia he observado eso, que nosotros organizamos eventos, sí vemos que la gente asiste buscando que se le llene el expectativa que y ya arrastramos mucho años atrás, pero que también habla de que no tiene conocimiento de su enfermedad. Hay quien llega a nuestra mesa de inscripción para decir “es que quiero ver si yo todo el tiempo voy a tomar hipoglucemia antes, porque le tengo pánico a la inyección de insulina”. Y tú lo ves, y dices hijote, pues y si usted hubiera tratado con insulina la aseguro que tendría una mejor constitución física y una vida mucho mas agradable. Ese es el contraste que se puede hacer.

E: ¿Y cuando viene la mayoría de la gente?

P: Cuando se sienten mal. Y no solo cuando se sienten mal, cuando tienen recursos económicos. Una de las limitantes mas grande para nosotros es ese. Si uno dice al paciente que tiene que venir cada mes, se hace concesiones para dar paquetes, en donde te escribo en doce sesiones y te cobro diez. Con total que la persona no se vaya. Con esa cuestión de “es que doctor no vengo por que no tengo para pagar la consulta”. Y creo que es eso, un problema muy grande en México. Por que la atención en los sistema de salud del país están tan saturados yo no me atrevo decir que es no nos atiendan. No, yo digo son gente experta, como nosotros que están saturados. Entonces no pueden dar el nivel de calidad de atención de nosotros hacemos al nivel privado. Mientras nosotros, podemos tardarnos una hora, dos, en el paciente dependiendo de la problemática que trae. En seguro social le dan 15 minutos en general. Yo creo que eso es un problema que . Y que hemos trasmitido también a la autoridad.

E: Y con respecto al acceso, ¿en general si la gente tiene acceso? ¿A parte que si no tiene recursos económicos, sí existe lo suficiente para una ciudad del tamaño de Morelia?

P: No. No hay suficiente personal, no hay suficiente gente. Por ejemplo, hablan por la guía telefónica. Nos localizan porque dice directamente "atención en diabetes". Entonces la gente dice " a que doctor debe recurrir si tengo diabetes?". Empieza por ahí, "rinólogo, internista, medico general, que especialidad?" Nos pregunta. Entonces yo les digo, no es la exclusiva un medico internista, no es la exclusiva de un medico familiar. Nuestro centro por eso tenemos varias personas, con diferentes especialidades para tratar integralmente tu enfermedad. Y ahí se marca la diferencia. También es el conocimiento es de siempre. A quien recurrir? Aquí en Michoacán agarrar el periódico y busco médicos, no. Y la otra pregunta que solemos hacer con alguien llega, es que dicen 'es que yo ya fui atendido", y como se siente? Con la medicina que le dio, usted cree que funcionó? No, porque fíjese me siento mal. "Y aunque me la daban la medicina, como que yo necesito", dice el paciente, "venir a platicar con usted para decirle que tengo un montón de cosas que no es cuestión de la enfermedad. Pero que me está pasando alrededor de mi familia y no sé como resolver." Y entonces aquí organizamos platicas para hablar con la familia, en especial la adherencia y tratamiento del paciente, la aceptación de la familia para el paciente que se tiene, y para evitar ese señalamiento de que o en la familia hay una persona con diabetes y todos giramos alrededor de él. Entonces en nuestras platicas es lo mismo que pasa con un alcohólico. No vamos a girar alrededor de él. Vamos a tomar la enfermedad de nuestro compañero, nuestro esposo, nuestro hijo o hermano como un reto. Y juntos vamos a aprender como chivar la enfermedad. Porque a lo mejor en la mañana no es el único integrante de la familia que la tenga, uno. Dos: porque si no se cuida es posible que tenga complicaciones ¿y ahora quien lo cuida? Tres: ¿y si no hay quien lo cuida, la cuestión económica cómo está? Cuatro: en un momento dado cuando ya tengamos un paciente y que hay que mutilar porque no estuvo con control tiene pie diabético, que sé yo, ¿quien es el sostén económica de la familia? ¿Para donde se va a ir toda la familia? Entonces la idea de nuestras platicas con la familia es para delantarnos. Para decirle. La situación del paciente en este momento es esta, en 5 años puede ser esta, en 10 años puede ser esta. Observemos, hijos pequeños que se vuelven en adolescentes, adolescentes que se van de casa, se van de casa, se queda un señor y una señora. Si uno de los dos tienen diabetes que van a hacer? Como vamos a hacer? Que la enfermedad es crónica, que cuesta. Y que todos tendríamos que hacer un ejercicio de identificar la enfermedad crónica para vivir con ella. Pero no el estigma ni hay que sacrificarnos todos.

E: ¿Y se ve mucho de eso, que la familia apoya al diabético o a los diabéticos?

P: El éxito es a través de un decálogo que tenemos. Empieza por decir mi persona, termina por decir la familia en general, y termina por decir con respecto a otros igual que yo. Y cuando aquí empieza a negar cual de estos puntos no estas cumpliendo? Porque dice aquí que me hago responsable, que voy a seguir mi tratamiento, que voy a hacer algo, y no vas a hacer nada, decídete y vete. Porque el usuario de aquí o el crecimiento que te estamos ofreciendo es función de tu familia. En función de otros que tenga el mismo padecimiento y en función de la sociedad.

E: ¿Y con respecto a los diabéticos, en cual aspecto se enfocan ellos?

P: Depende. Por ejemplo si es un niño me pregunta: "¿toda la vida voy a seguir así?" "¿Voy a poder hacer deporte?" Cada quien tiene su cuestionamiento. Los niños se enfocan en lo que van a hacer en el futuro. No están pensando en lo que me van a cortar una pierna. Están: "¿y yo voy a ser igual a los demás? Cuando son mas grandes: "¿podría casarme?" "¿Puedo tener hijos?" Cuando ya van con una evolución de la diabetes mayor: "¿Qué de las complicaciones?" Entonces cada quien tiene una pregunta que hacernos. Y hay algo otro que es muy importante. En el hombre, es que empieza a perder la potencia sexual. Entonces mi trabajo de tesis doctoral, fue precisamente sobre un aspecto de trato a favor de la modificación de moléculas hormonales en

barones para mejorar su calidad de vida. Entonces dependiendo de quien hay un momento dado es la preocupación.
E: ¿Al final se creen los pacientes capables de mantenerse? ¿O si tienen miedo, o se sienten capable?
P: Es innegable que en las primeras entrevistas la gente viene con miedo, es mas una de las cosas que a mí me toca como responsable de la educación. Cuando pasan con el doctor después vienen conmigo. Y yo les empiezo a hacer cuestionamiento sobre cual es su plan de vida en un año? 5? 10? Y ahí empieza a salir los miedo. Pero si es cierto hay un miedo mucho mas marcado para la muerte. Yo he estado en oncológica. Mi tesis de maestría fue cáncer mamario. Pero si noto la diferencia entre que, a lo mejor lo que existe es mayor difusión de lo que es diabetes, y entonces la gente en cuanto se sabe que tiene el diagnostico, y hazte cuenta que te vas a morir de ella, el miedo viene desde este primer instante en el que se lo diagnostica, y no hay una aceptación digamos a tiempo. Les lleva muchos meses aceptar lo que tienen. ¿Cómo podemos acortar esa distancia? Lo analizamos nosotros y dijimos es puro conocimiento. Si no le empieza a decir lo que pasa es que el páncreas esto, o lo que pasa es que no solamente el páncreas se daña sino otros órganos etc. Empezamos tal vez en decir empieza a cuidarse, que hay que seguir las indicaciones medicas, que hay que hacer que la vida continua, que no puedes meterte debajo de las sábanas y dice tengo diabetes y ya no quiero salir. Y tal vez, una de las cosas que más revisamos son los estadios de depresión. Ahí tenemos un trabajo nosotros sobre la depresión. Si hay un índice inclinado de depresión. Entonces es importante detectarlo, el doctor que hace la consulta terapéutica. Vas a caer en el mismo depresión vas al sicoterapuetico. El miedo viene acompañado a una no aceptación y el acercamiento de la muerte. Pero yo creo que eso lo tenemos nosotros, verdad?
E: Sí.
P: Entonces en mis practicas voy a empezar a tratar algo sobre tanatologia.
E: ¿Y eso, que es?
P: Es preparándonos al voy a morir. Para cualquier ser. Entonces quiero meterlo aquí. Hacer eso, y dar algunas platicas. Porque nos debería a los que tenemos, al algunos que tiene algo, y a los les dicen que tienen una enfermedad Terminal.
E: ¿Y con respecto a la comunicación a la gente que puede ser diabética, que cree que es la mejor manera de abordar eso? Porque mucha gente si no lo son, pues..
P: Pues yo creo que en los programas educativos, que se supone que debe de haber en todas las escuelas. Pues, eso el razón que no he dejado de ir a la escuela a estudiar. Pues debe haber un seminario, una platica, una charlar una vez al mes dirigido a la comunidad porque la institución, porque soy voy a meter aquí los profesores, los estudiantes, y los graduados y los reprobados, pero y que de sus padres, y que de su familia, que de sus novios, los que no están inversos? Dar una especie de platica, tipo cultural. Y de ahí meter muy sutilmente, yo vengo de una platica de autoestima, y resulta que yo meto un párrafo de las enfermedades crónicas. Algo de autoestima y digo que voy a hablar de una enfermedad crónica- la felicidad. ¿No? ¿No querrían enfermarse de esa enfermedad crónica que es la felicidad? Y todo el mundo, "¡pues si!". así que como un pues si, escuchar un pues, no. Si les digo que es diabetes o SIDA. Y hacemos que las cosas trasciendan bajo este plantemiento-que puede ser feliz teniendo tu enfermedad. Y empieza a platicar de la gente es discapacitada. Que tiene una sola pierna, que solo tiene un ojo, pero que sigue viviendo y que hace cosas buenas. O que tiene logros y ponemos su fotos. Y ponemos un fotos veamos, es una foto de una persona. Que nos imaginamos, te voy a platicar que es campeón, es no se que, no se cual. Y ahora le saco la foto-que es parapléjico. O esta mujer que

cree que es su preocupación es que no tener hijos. O resulta que es la representante de un campamento de niñas, pero niñas que eran de la calle. Resulta que es la mama de 80 en vez de una. Entonces la definición de la autosatisfacían de tus sueños, dime cual es tu sueño, y dime que te detiene. Yo creo que eso hay que hacer en las escuelas. Podríamos hacer que alguien que no quiere estudiar se retire, porque no quiere estudiar. Y puede seguir siendo feliz. Cuando sus capacidades son otras. Pues, ponerse a ser un comerciante, no necesariamente un intelectual. Pues desde mi punto de vista, después de tener ya tantos estudios de post grados cuando me dicen, usted recomendaría que la gente estudiaran doctorado? Yo les digo no. ¿No? ¿Por qué? Mejor le preguntaría, tu querría eso. Si tú me dices si, te digo como. Y ahí vamos. Pero necesitas la primera respuesta de necesidad. En las escuelas cuando mis hijos asiste una escuela, hablo que la directora y le dijo usted tiene un programa cultural, "pues si, este mes no tengo ningún ponente" Me autopropongo. No sabe quien soy, no sabe que voy a dar, pero si hay que llenar el programa. Y que ha pasado? Que depuse de eso, hacemos un programa de platicas para incidir. Yo pienso que eso es el estrategia. Para muchos de nosotros que queremos incidir no este en el costo de la ponencia. No este que me invites. Si no me autopropongo como a propósito. Y que va a incidir para mis hijos y para todos los demás. Adonde están ellos y donde esta el medio. Entonces como no puedo incapacitarme para no hacer algo. De lo que a lo mejor, Dios nos dio un don para transmisión de conocimiento. La sensibilización de la población. No me lo hubiera pensado. En ese momento, pues, ya lo estoy pensando.

Interview with Dr. Marques, M.D. Urban Health Center

Patient visit/interview with Alicia León López (P4) & Gloria Hernández López (P5)

M: Lo que seguimos en diabetes es una dieta, o sea no dieta, dieta es lo que come una persona en un día, coma lo que coma. Pero nosotros les damos alimentación saludable. Es decir alimentación balanceada. Que tenga los cinco nutrimientos fundamentales, que es azúcar, o sea hidratos de carbono, proteína, grasa, minerales, vitamina. Y añadimos un poco de fibra. Entonces, ellos tomaran una alimentación adecuada en relación a su peso, a su índice de masa corporal. Entonces empiezan a hacer ejercicios y empezamos a controlar la diabetes. No mas que a veces a ellas les cuesta mucho trabaja hacer la dieta por sus costumbres. La gente Michoacana lo único que no se como del cerdo es la pie.
A: Los pelos.
M: Se toma las vísceras, [TALKING TO PATIENT] y eso es mal para tí, tomar las vísceras, tomar la grasa de puerco. Pero no se quiere tomar un bistec de puerco de carne maciza, sin grasa. O tomar, carne blanca. El pollo, el pescado, el pavo, ternera y si no tienes eso pues puedes tomar requesón.
A: Frijoles también nos hacen daño?
M: Los frijoles no, son leguminosos. Las leguminosas como el frijole y las lentejas, con moderación. Pues si no tienes carne comes unos frijolitos. Pero, por favor tu verduras al medio día, hojas verdes. Espinacas. ¿Qué otra conoces tú?
A: Challote,
M: No, dije hojas.
A: ¿Hojas?
M: Sí

A: Espinaca, verdolaga,
M: ¿Verdolaga, que mas?
A: Lechuga.
M: Lechuga, muy bien.
A: Pues, Coliflor, brócoli.
M: Brócoli. ¿Ya lo entiendes? Ya mencionaba hojas verdes. Y tu carne, de blanca. O roja también, pero menos roja y mas blanca. Entonces tienes que venir el lunes a desayunar conmigo.
A: ¿A qué hora?
M: A las 10. Y entonces vas a saber a dejar esta dieta. Yo tengo este guía. Esto lo copias mas chica. Y que te la miquen. ¿Desde cuando eres diabética?
A: como 4 años.
M: Alicia León, López. Pero vienes, eh.
[FILLING OUT PAPER WORK]
M: ¿Mira cómo vienes del azúcar? ¿Y qué tomas de alimento?
A: Pues, a veces avena o…
M: No, pero por la mañana que desayunas?
A: ¿Es que te hace daño?
M: ¿Por eso…tomas leche?
A: Leche con café.
M: ¿Un vasito de leche con café? Está bien.
A: O a veces avena.
M: Avena con un poco de leche. Hay 4 cereales que no te pueden faltar: que es el arroz, la avena, trigo, y maíz. Son los 4 cereales importantes. Por eso te tienes que tomar tus cereales. Por ejemplo para el desayuno, que te parece dos tortillas de este tamaño o un bolillo. Porque los tortillas de este tamaño valen igual a medio bolillo. Pero cuando tienes dos raciones de pan tendrías que tomar dos tortillas o el bolillo completo. Normal, el bolillo. Y entonces tienes que seguir tu alimentación saludable. En la mañana la leche. Si fueras lista tu tomarías dos claras, dos claras de huevos, fritos.
A: ¿Las puras claras?
M: Sí, no tome la yema. Porque tiene mucho colesterol la yema. Pero las claras son muy buenas. La clara es una abomina durísima. Y es una proteína muy buena para ti. ¿Y qué medicina tomas?
A: Pues estoy bien con el doctor, Felipe.
M: ¿Y qué te da Felipe?
A: Estas pastillas.
M: ¿Enséñamelas. Esta, esta bien, y como tomas esta?
A: Una en la mañana, y una de estas. Y a medio día nada mas uno de estos. Y en la noche otra vez dos.
M: Pues tú tienes que tomarte una pastilla de estas antes de cada comida. Y tienes que tomarte la metformina la mitad.
A: ¿La mitad? ¿No me la tomo entera? ¿Dos al día?
M: Prefiero que tomas la mitad. Y te tomas media tableta con cada comida. CON. Es decir con tomas tres bocados y te tomes la mitad de esta. Y aquellas se toma antes. ¿Ya descapistaste?
A: Sí.
M: Media tableta con cada comida
A: Sí doctor. O sea se acaban en un mes.

M: Bueno, así las vas a tomar. ¿Y cuantas tortillas te comes?
A: A veces tres…
M: A veces cuatro…
A: Ya De cuatro no paso.
M: Tienes que tomarte dos de este tamaño. Te toma tu café, o tu avena. Y te tomas 2 tortillas de este tamaño. O si no te tomas un bolillo entero normal. Te fríes tus dos claras, y te las tomas con unas de las tortillas. Y te tomas un jugo de naranja.
A: Sí doctor.
[writing prescription]
M: ¿Y ha tomado dulce?
A: No, ahora no.
M: ¿No ha tomado nada dulce?
A: Sí tomo dulce pero el dulce de la Splenda, del sobresito. Eso es lo que me hecha en el café.
M: La [pill] la tomes antes, la mitad. Y dos cajas, tabletas. Metformina…850[mL] tomar media tableta. Con cada comida, son tres comidas. ¿Estamos?
A: Sí.
M: No me falles, doña.
A: No.
M: Y no te tomes mas que dos tortillas, porque te tomes a veces cuatro.
A: Sí, a veces tomo cuatro.
M: Y no te mandes el azúcar. [writing] Y nos vemos aquí dentro de 10 días.
A: ¿Y el lunes vengo?
M: Sí a desayunar conmigo. Pero VIENES. Y dentro de 10 días vienes a hacerte la prueba y a ver como estas.
A: Gracias.

E: ¿Me puede firmar el consentimiento para usar este entrevista en mi investigación?
A: No sé leer.
E: ¿Cómo hacemos?
M: Pregúntale.
E: Me da su consentimiento para usar este entrevista para mi investigación?
A: Sí.
E: ¿Y hace mucho tiempo que eres diabética?
A: Pues, de lo que yo se hace 4 años.
E: ¿Y siempre viene aquí, al centro de salud?
A: Sí, sí.
E: ¿Y cada cuanto viene aquí?
A: Cada mes.
E: ¿Y te hacen la prueba?
A: Sí. Y ya.
E: ¿Y sí es fácil conseguir una cita aquí?
A: Sí.
E: ¿Y siempre te atiendan?
A: Sí.
E: ¿Y que dificultad te parece es cuidarse con la diabetes?

A: Es que ya esta uno dispuesto a comer de todo y la coca que se te antoja.
E: ¿Y que es lo mas difícil?
A: Pues, para mi es eso.
E: ¿La comida?
A: Hace daño la coca, no?
M: Sí hace daño.
E: ¿Y has llegas a cambiarse la dieta?
A: Luego, es que si se descuida uno para que has hecho un traguito y ya va para abajo.
M: Nada de eso.
A: No, ya no nada de traguito.
E: ¿Y esto que crees que son los factores con contribuyen a la diabetes. ¿Qué te causó la diabetes?
A: Pesaba 110kilos.
M: La obesidad
A: Yo digo que eso fue.
M: Sí, eso fue.
A: Pesaba 110.
M: Y tu mama o papa lo son.
A: No.
M: ¿Nadie mas, hermanos diabéticos?
A: No, tengo nada más una hermana y ella no la tiene.
M: Pesabas cuanto?
A: 110 kilos.
M: Que bárbara!
A: Tenia unos brazotes, doctor. Todavía me cuelgan. Baje 50kilos. Peso 60k ahora.
E: ¿Y como hiciste para bajar?
M: ¿Y bajaste?
A: Pero rápido.
A: Dije, ay que bueno que estoy rebajando. Y vine, y no, la traía bien alta. Y ya empecé a pues, tomar medicina, como no se ha bajado bien, de 300 no pasa, 230.
E: ¿Y como te afecta por ejemplo, la vida cotidiana?
M: ¿No tienes coraje? ¿No tienes penas en tu casa?
A: Pues, no.
M: ¿Ah, segura?
A: Pues, a veces sí, a ver que…
M: ¿Y tu marido es bueno?
A: Pues, ahorita ya mi marido es bueno. Antes era mas (trails off), ahorita ya mejor, como que el sí esta.
M: ¿Ya está mejor?
A: Ya, ya. Tomaba mucho. Le digo, mira a mi no me importa que tomes, [INAUDIBLE]. Tu toma hasta que quieras. Hártate le digo, pero no vengas a molestar. Que ya te cansaste tomar bien, cena y a dormir. Y el que, ay esto y el otro. Y pues uno sí, le daba coraje.
E: ¿Y te ayuda en alguna manera con respecto a la diabetes? ¿O con tomar las pastillas? ¿O acuerda de tomar las pastillas?
A: Sí me acuerdo.
E: No, tu familia.

A: Ah, sí.
E: O de comer bien.
A: Sí, mi hija. Le digo, vamos a comer, y me dice " ah no mami esto te hace daño". Tu comete esto, y ya ella a veces trae su coca, y me dice tu no tomes.
E: ¿Y ella se cuida bien, ella misma?
A: Sí.
E: ¿Bien, Y sí es de Morelia?
A: Soy del Rancho el Cerro, pero aquí desde niña. Tenia 3 años cuando me trajeron para acá. Aquí he estado. Aquí me case, aquí seguía.
E: Pues, muchas gracias.
A: Sí, ándale pues. Adiós doctor
M: No se te olvide venir.
A: No.(leaves)

E: ¿Así la primera cosa que enfatiza es la de comer bien, y luego?
M: El ejercicio
(Enter New Patient)
M: ¿Y como te llamas tú?
G: Gloria Hernández López
M: ¿Y cuando supistes de tu diabetes?
G: pues, no yo ni cuenta me daba que tenía diabetes
M: ¿Hasta cuando supistes?
G: Hace como un año, que fui a una similar y allí me dijeron que tenia 10 años con la diabetes.
M: ¿Esto es lo que te dijeron?
G: Esto me dijeron.
M: ¿Pero tu lo supistes hace un año? Eso Es. ¿Y que medicina tomas?
G: Tomo la, me dio la misma de ella, la vidanclamida,
M: No me hables de ella
G: Con la metformin, y ya está. Y esta me la acabe.
M: Esto esta buena.
[interruption from assistant and another doctor]
M: Esto, tu la compras? (holding her pills)
G: Sí.
M: ¿Y cuanto te cuesta?
G: Me cuesta, 85 creo.
M: ¿85?
G: Sí
M: Entonces, la vas a tomar, pero me haces el favor de que la tienes que comprar esta. Yo te puedo dar una receta en donde están separadas. Y te la doy así para que no te gastes. ¿Eh?
G: Sí, doctor.
M: Y luego vienes a verme dentro de 15 días. Y quiero que vengas el lunes para desayunar conmigo.
G: También me da ahora, me vine porque me da un dolor en este lado y me corre toda la cintura.
M: ¿Te lastimastes?
G: No, doctor, no me he caído No le he hecho nada.
M: ¿No te has caído?

G: No. Y la comida me da mucho asco. No me da hambre. Doctor.
[INTERRUPTION]
M: ¿Tu no tienes seguro popular?
G: Apenas, es la primera vez que vengo a consulta con seguro popular.
M: ¿Ya tienes tu ficha de seguro popular?
G: Sí.
M: Esta pastilla es 5mg, te vas a tomar una antes de cada comida
G: Sí,
M: Antes, sí. Desayuno, comida y cena.
G: Sí
M: Y luego, te vas a tomar dos tabletas de metformina
G: Sí.
M: Metformina de 850mg y vas a tomar, media tableta. La partes. Es grande.
G: Sí.
M: media tableta. En medio del desayuno, la comida y la cena. Tomes res bocado y te tomes media tableta. Media tableta con cada comida. ¿No se te olvida?
G: No
M: ¿Cuantas tortillas te tomes?
G: Pues, ahorita no me como ni uno, porque no me da hambre.
M: Necesítas comer.
G: Y no como. Y ya ando así repitiendo mucho como si estuviera acabadita de comer. Como si hubiera salido de comer.
M: Pero me comas picante, eh.
G: Sí, doctor No comeré.
M: Y te vas a aliviar. Pero no comas picante. Y te tomas tu medica, pero no puedes dejar de tomar tu alimento porque si no, te hace daño la medicina. Y nos vemos el lunes a las 10para desayunar conmigo. Y te tienes que traer esta dieta. La fotocopias, y que tu la hagan mas chiquita, y que te la enmique. Para que vengas conmigo as las 10 y te voy a enseñar como comer.
G: ¿Bueno, entonces esto es mió?
M: Llévate tu papel.
G: Mi tarjeta. Gloria
M: Aquí esta. Y tienes el azúcar regular, no es tan seria.
G: ¿Y la tarjeta se la pido allá?
M: ¿Cual tarjeta?
G: El carné que me dieron
M: Ah, esto se lo pides a la chica y nos vemos en 15 días.
G: Sí doctor.
M: Y si vienes a que te haga la prueba, nada mas.
G:Adios Doctor (leaves)

E: ¿Y me puede hablar un poco sobre los ejercicios y el autoestima de que me hablo antes?
M: Entonces, nosotros tenemos tres factores antes importantes: el paciente diabético cuando es diabético, cuando sabe que es diabético, entra en un conflicto existencial. Si piensa que le van a cortar las piernas, si se va a quedar ciego. Entonces el entra en este conflicto. Y uno tiene que manejarlo y educarlo. La educación del paciente diabético, no es una información, es el tratamiento mismo de la diabetes. Esto lo dijo Dr. Joslin, se murió de 100 años, la clínica Joslin

de la cuidad de Boston. Y después la organización mundial de la salud dijo, que la única forma de que el diabético aprenda vivir con la diabetes y tenga relaciones normales con la sociedad es que reciba educación. Nosotros podríamos tener la medalla de la victoria de la clínica josslyen. Pero no la podemos comprar y entonces buscamos la manera de darles algún premio, y reconocimientos a sus esfuerzos. Y algunas son muy listas, muy capaces. Algunas. Y siguen a pie la letra su ejercicio. Y lo hacen diario, como deben de hacer. Y el ejercicio del baile. Y, ¿por qué hacemos baile? Porque no es posible ponerlas hacer ejercicios que las pongan en riesgo. Por su edad, por su presión arteria. etc. Y claro siguiendo la norma, pues, escogemos. Les hacemos las fuerzas. Les hacemos electro. Y les revisamos bien para que entrenara ejercicio, Y el ejercicio tiene un sentido. Durante el ejercicio, el músculo gasta, absorbe cosas sin necesidad de insulina. Así que el paciente ahorra insulina. Y además disminuye la resistencia a la insulina el ejercicio. Y lo tenemos formados por etapas, es decir, primero hacemos calentamiento. Depuse hacer ejercicio, después estiramiento, y finalmente relajación. Los enseñamos meditar. Pues para vaciar su consciencia de tantas cosas que traen en la cabeza. Algunas las cuales son tremendamente amargas. Y esos les ayuda y le va mucho en el autoestima. Y les decimos que la belleza de una mujer esta en su personalidad. Que eso es lo que va la ley de la suerte de la bonita, la fea, lo que sea. Porque la etapa de saberse diabética, es una etapa crítica, y tenemos que educarla en la forma adecuada con los objetivos señalados para la sobrevida. Es una etapa de sobrevida. Una vez que ellas triunfan en ella y salen adelante ya viene lo que podría educación continua. Ya viene la clase de nutrición la clase de diabetes, y los consejos y así se había quedamos. Bien remera. Les damos consejos.
[INTERRUPTION]
Entonces te decía yo durante el ejercicio los quema el azúcar de los músculos. Y el ejercicio es uno de los actores que ayudan a vencer la resistencia insulinita propia del sistema metabólico de la diabetes. Y lo importante es que bajen de peso. Si están en sobrepeso o la obesidad. Bajando de peso disminuye la resistencia, se vuelve el paciente mas fácil de controlar. Y así, luego la alimentación en rigor, tienen que hacer una alimentación suficiente, pero no excesiva. Y le damos a tomar los alimentos para que el paciente utilice sus nutrimientos. Una cosa es el alimento. El alimento es lo que se puede conseguir, está al alcance de la gente y con ese algo controlamos. Y les damos leche en la cantidad adecuada. Les damos este, carne, verdura, y fruta. Y la carne pues es un alimento que mejor destacar, y los enseñamos a tomar los cereales, las leguminosas, que son los frijoles y las lentejas. Y entonces esta poco lo que deben comer.
E: Y con respecto a toda esta información y mas información, ¿sí, cree que hay suficiente aquí en Morelia? ¿O que hace falta más?
M: Yo que veo en Michoacán, como somos latinoamericanos, la diabetes, somos más proclives a la diabetes. Y la verdad las cosas este, no dudo que tenemos el primer lugar de la obesidad en Michoacán. Por la forma de comer, y tu lo ves en la calle. ¿Siempre hay de dos por uno, verdad? Entonces, el índice que te de es de nutritivos. El michoacano es proclive a la diabetes. Y él que te dice que lo aceptemos, párate. Pero la necesita. Entonces, los enseñamos a comer, los enseñamos a volverse Los vigilamos, vamos controlando su índice metabólico. Y generalmente les va bien. Pero allí hay casos que no podemos solucionar. Por despego al tratamiento. Te das cuenta? Entonces, es un bajo estimulación, no se aprecia a su mismo… Aquí en Michoacán habrá un paso de 100mil de diabéticos. Pero si junto los que hay en los Estados Unidos, los michoacanos que hay en los Estados Unidos hay mas allá que aquí. allá debería estar unos 7.5millones, y de aquí hay 4 en total. Y estuve en Nice, California donde está Schwarzenegger. Y estuve porque iban a poner una clínica de diabetes. Y lo estudiamos bien. Les damos

educación para que no lleguen a complicarse. Lo que pasa es que de todas maneras, algunos pueden con el paquete del control del glucemia, del control del colesterol, del control de otros factores. Pues, muchos responden bien. Andamos alrededor de 65% de eficacia.[M. Nods off]
M: Ya me dio mucho sueño. Es la hora de que haga el azúcar.
E: ¿Usted también es diabético?
M: Sí, y tengo 35 años. Entonces te pudo decir en general que siguiendo las predicciones que por el año 2025 tengamos en el mundo mas 700,650 millones de diabéticos. Por la forma de comer, por la idiosincrasia de nosotros, y porque somos muy proclives. Y en EEUU ha aumentado el numero. había 20 millones hace unos años. Ahora creo que hay mas. Y la población latina, y la población morena, pues tiene mas. Somos mas proclives nosotros. Pero ellos son mas proclives a otros enfermedades. Entones nosotros tenemos que parar esto. Y la metodología es que tenemos las normas. Las normas con control la diabetes y son manejadas por la secretaria y nos dan las normas. Y las normas antiguas decían que la insulina no debía estar en un centro de salud. ¿En donde vamos a parar el semejante ola de la diabetes? Lo paremos en el hospital. El hospital es para ayudarnos a solucionar problemas mas graves. Amputaciones, el manejo de ceguera etc. Es un juego difícil. Nosotros vamos a tener una camera especial y podemos retratar la retina, sin delatar la retina. Y es buena la camerita. Esta probada. Y entonces yo con la misma camera mando al enfermo al segundo nivel. Entonces el problema de las complicaciones. Nosotros sabemos valorar las complicaciones del juego. Y realmente hay mas despego de este tipo. Pero si no hay ningún despego, y el paciente se porta bien en cuanto el alimentación, a seguir la dieta, ha ganado. Pero no todos. Sola una cantidad. Y tenemos bastanstes. Y son controlados. Buenos, si quieres venir mañana…

Interview with Javier Coria, Director of Communications (IMSS) (H4)

Interview starts in mid sentence
J: La transculturización te permite asociar la diabetes con residentes en los Estados Unidos y cómo cambia. Cómo la cultura va cambiando va cambiando los métodos de alimentación en la población. Porque tú sabes aquí en México somos el primer lugar en obesidad infantil en el mundo. Y en adultos somos en 2º lugar. Solamente nos gana los estados unidos. Y el te puede dar un panorama incluso regional, internacional, mundial, ¿no? Claro, eso si lo sacas en Internet, pero eso te da un panorama de que es la obesidad y el sobre peso. Es uno de los principales problemas de todas las instituciones publicas y privadas en el país. Porque se va una gran derrama económica de las instituciones en la atención de enfermedades crónico degenerativas derivadas de la obesidad. O bien ya no crónoicodegnerativo porque son adultos mayores. Ya en enfermedades infantiles o a edad temprana derivadas también de la obesidad. Entonces por eso es de que el te hablaría de la obesidad asociada con la hipertensión, o la diabetes, asociada con la hipertensión, la insuficiencia renal crónica. Y de allí ya se deriva todo lo que te comentaba de los transplantes. Que es una vista también muy importante. Pero en México hace poco en todo el país con una televisora nacional hubo una cruzada nacional en contra de la obesidad que se llama *un millón de kilos menos. L*a situación era realizar al nivel nacional un Reality Show con gordos, con obesos. Que nos pusieron rigurosamente a dos fases primordiales: ejercicios, activación física, y la otra, comer bien. Dieta, comer bien. Entonces, mientras uno veía el reality show allá en la televisión, en todos los estados, todos los estados tenían que aportar de acuerdo al numero de derecho habientes en cada entidad, tenían que aportar kilos, entre comillas. Entonces

inscribimos a todos los timbones a todos los obesos en cada estado lo que quisieron. En cada unidad lo reclutabas. En cada estado puso kilos. Para el termino de dos meses, dos meses y medio algo así. Tan solo ese millón de kilos le representaba al país, un ahorro de 19mil millón de pesos menos.
E: ¿Y es la primera vez que hicieron algo así?
J: Es la primera vez nacional. Por los focos rojos. Focos rojos, rojos, rojos en cuestión de la obesidad. Entonces el te puede hablar de este programa. Y al lo mejor puede bajarte datos en cuestión de Michoacán. Y él te hablaría, yo creo a tí te interesaría mucho saber como ha venido cambiando la cultura de la alimentación de la población por este flujo población de ida y vuelta a los Estados Unidos. El mayor problema de obesidad en Michoacán, te lo puede describir él, se centra en comunidades indígenas. En donde su alimentación es a base de maíz, pozole, tortilla, tamales, tacos, tostadas todo eso que conlleva maíz. Pero luego como cambien los de esta región, que se van a los EEUU, ha dejado ese tipo de comida también, con un nutriente muy serio, en contra de la salud. O lo que favorece la obesidad, y en cuanto parte cuando vienen de allá, vienen con la cultura de los hotdogs, las hamburguesas, etc. Entonces es un cambio, pero sigue siendo una dieta no lo mas saludable para el ser humano. Entonces, en esa dieta a lo que nos sometieron en Michoacán, por ejemplo, pues cual dieta a comer cinco veces al día? ¿¡Entonces, cual dieta?! Pero era a comer lo elemental. Es decir entre el desayuno y la comida hay un entremés. Y entre la comida y la cena hay una merienda. O sea comes mas veces, pero comes mejor. Y con eso en dos meses, ya te digo la población mexicano con la activación física, y una dieta, sana y balanceada. Aporto mas de un millón de kilos.
E: ¿Y como se comunicaba sobre el alimento, la comida? ¿Cómo hizo, una campaña aquí también?
J: Sí, fue una campaña de medios. Una campaña entre la población. De aquí de Morelia, igual así como la bajaron del estado igual a cada unos de los hospitales. Del interior del estado. Y de cada uno de los hospitales lo bajaron a cada una de las unidades medicas familiares que hay en las principales regiones del estado. Y ahí iba la gente a inscribirse. El que quiso. Pero dio resultados. Dio resultados satisfactorios. Entonces yo siento que al nivel nacional ya se esta pensando en hacer una segunda campaña u una segunda fase también. Pero eso fue un éxito. Por el "boom" publicitario que le dieron los medios de comunicación.
E: ¿Y eso, cuando fue?
J: Eso fue el año pasado. Fue mayo/junio. Hace un año aproximadamente. Pero él te da cifras de las enfermedades. Eso incluso de cifras de las amputaciones de extremidades inferiores corporales. Producto de la diabetes. Tanto en el área rural como en el área urbana. No, no es afondo esto. A lo mejor no te lo da en una primer platica tu coméntale algo que te sirva de esta platica. Que te le puedes decir, hábleme de eso, eso, y eso. Pero es muy interesante eso, y a verdad le conviene a todo el mundo que se habla al respecto.
E: ¿Y antes, cree que la gente se interesaba por el tema de la diabetes? ¿O solo la gente que sufre de la diabetes? ¿Por ejemplo investigar o saber sobre ella. Porque la verdad es que va muy mal aquí, ¿no?
J: Lo que pasa es que tu ves a más gente, este, diabética, previniendo algún desenlace fatal. Son mas pocos los diabéticos que la están controlando en base a dieta o ejercicio. Y eso de ejercicio, tu lo ves aquí en la explanada del IMMS. Realizando alguna activación física. Y en contra parte, ves a mas diabéticos hospitalizados allá. Ves a mas diabéticos ocupando camas en un hospital que requiere también otra gente. Pero no los puede echar para fuera. Son de los travientes, y ha pagado su seguro, etc. Pero lo mas raptible sería la prevención. Y la prevención se da en la edad

joven, o adulta joven. ¿Cómo? Activación física y una dieta sana. Nada mas. Pero, yo siento que, a mi modo personal, el gobierno de la republica debería trabajar en dos vertientes mucho mas fuertes: uno en el sector educativo. Desde niños. Si un niño le enseñas desde chico que es lo que hace un refresco. El refresco es lo peor. Imagínate cómo combate la obesidad en el país, que más consume refrescos en el mundo, que es México. México es el primer consumidor de refrescos en el mundo. Entonces imagínate. Pero esta cultura de tomar el refresco en la mañana, la tarde y la noche. En lugar de un vaso de leche. Entonces, aquí el problema es meterte en serio en la cuestión educativa. Un pilar muy fundamental. Para que ahorita el numero de diabéticos, el día de mañana, vaya disminuyendo considerablemente, conforme esta población chica ahorita en la edad escolar vaya aumentando. Y dos, mayor incidencia de los medios de comunicación, de manera forzosa. La inversión en los medios de comunicación para acciones de prevención. En prevención yo te aseguro que todavía las instituciones, esta…muy disminuida. Porque la población derechohabiente te agolpe la consulta, te agolpa hospitales. Y tienes muy poco tiempo para la cultura de prevención. Entonces son dos pilares muy fundamentales. Sobre todo el aspecto educativo.
E: ¿Y que es exactamente el IMMS? Sí, sé lo que es, pero con respecto a por ejemplo el secretario de salud y otros hospitales. ¿Me puede describir un poco exactamente que es la diferencia? ¿O qué hace IMMS que es diferente en cuanto respecto a otros organizaciones de salud¿
J: El IMMS es uno de los tres pilares en lo que descansa la salud publica en el país. Primero esta la secretaria de salud, después esta el IMMS y en seguida esta el ISSTE.
E: ¿ISSTE?
J: ISSTE es el instituto de la seguridad social para los trabajadores del estado. Este es solamente para todos los burócratas, los maestros, los trabajadores de las dependencias federales. Ellos se van a atender al ISSTE. Ellos tienen ISSTE. Y en el IMMS son todos los trabajadores del país que cotizan en una empresa. Que trabajan en empresa, que trabajan en fabrica, que trabajan incluso en el campo. Que trabajan en algunas otras instituciones del gobierno, estatales y municipales. Los federales se van al ISSTE. Los de los trabajadores del estado se van al IMMS. Y en la secretaria de la salud estas toda la población abierta. La que no esta afiliada con ni el ISSTE ni el IMMS. La que no tiene seguridad. La que trabaja por su cuenta. La que en los sectores mas marginados. No tienen un ingreso, este, seguro cada 15 días. Verdad? Entonces estos, los sectores marginados, se van a la secretaria de la salud. Y ahí los servicios son mucho mas baratos que en las instituciones privadas. Por supuesto. Entonces eso es la diferencia. Pero el IMMS nació como una demanda de nuestro proceso revolucionario en 1910. El derecho a la seguridad social. Entonces es la institución de salud mas longeva del país, la mas vieja, y la que atiende al mayor numero de Mexicanos. Nosotros en el IMMS atendemos a mas de la mitad de los Michoacanos. Atendemos as 2,400,000 michoacanos. Divididos en dos vertientes. Una vertiente es la de IMMS Oportunidades, el área rural. Ahí atendemos 1,200,000 michoacanos. Y la del IMMS, del régimen ordinario, en el área urbana. Ahí atendemos así es la cuidad, poblaciones grandes ,etc. 1,200,000 michoacanos también. El IMMS oportunidad es un programa especial, diseñado para aquellas personas que esta inmersos en un programa nacional que se llama IMMS Oportunidades. Y este esta diseñado para las zonas rurales. Entonces, en el IMMS Oportunidades, en el área rural, también tiene sus propias unidades medica rurales. Una unidades apostadas en las comunidades mas alejadas. Donde tu te puede imaginar, a 50 metros de la costa Michoacán, hay una unidad medica rural. En la zona mas alta del estado en donde neva en enero, hay una unidad rural. Y en los mas recóndito. En el estado, en el IMMS

Oportunidades tenemos 335 unidades medicas rurales, y 5 hospitales rurales. Con especialidades, lo básico: pediatría, ginecología, traumatología, etc. Y este programa sobre todo, un de los mas grandes alcances que tiene, es que el disminuir la mortalidad materna, durante el embarazo. Eso es un gran reto para todas las instituciones de salud en todo el país. Y en el área urbana, en el régimen de IMMS Oportunidades, donde te digo que también atendemos a 1,200,000 michoacano. Acá hay 9 hospitales, y 47 unidades medicas familiares. Acá se llama unidades de medicina familiar y allá se llama unidades de medicina rural. Ese es el esquema a groso modo como esta organizado el IMMS. Y el IMMS también descansa también en tres vertientes principales. La primera es los servicios médicos. Es decir a donde vas a ir, es el jefe medico del todo el estado. El es que se carga de eso. El primer pilar es prestaciones medicas. El segundo pilar es el de afiliación y cobranza. Eso es tan importante porque eso es de la lana. El es que se encarga de recoger todo el dinero que los patrones le pagan al instituto por tener asegurado a sus trabajadores. Y otra parte la paga el trabajador el asegurar. Pues, el es que se encarga de todo el recurso y después de distribuirlo, no? Por eso es muy importante. Y la otra vertiente principal del IMMS es la de prestaciones económicas y sociales. Un trabajador no solo tiene seguro medico. Si se trata de una trabajadora, una mujer, esta tiene derecho a guarderías. Entonces en el IMMS las guarderías son la mejores con todo. Y lo que haya sucedido allá en Sonora, te diste cuenta lo que paso en la guardería de Sonora?
E: No.
J: Hubo un incendio en esta guardería y fallecieron 48 niños.
E: ¿Esto cuando fue?
J: El 5 de junio, de este año.
E: Ah, sí.
J: Y esto le ha puesto el ojo en todas las guarderías. Que es que si cuenta con detectores de humo, salidas de emergencias, ventilación y todo. Es una desgracia, ni modo. Pero, entonces hay una madre trabajadora, no solamente tiene el servicio medico, sino también la prestación de que a su hijo se lo van a cuidar y hacer de el. Esto es una prestación. Y la otra prestación económica es cuando tu tienes varios años trabajando y cumples 60 años y cumples semanas de haber afiliado con el IMMS desde pagas del trabajo. Te dan una pensión. Entonces es también es una prestación económica. Que aunque mínima, te sirve esta en tu retiro. Entonces prestaciones muy importantes que tiene el IMMS que no tiene otras instituciones privadas. Te podrás atender en el privado aquí en Michoacán, todo muy bien si tienes dinero. Pero bueno, no sabes el día de mañana. En cambio a caso te retribuye en medicina de alta especialidad. Por eso te estoy dando el ejemplo, por eso pongo el ejemplo de los transplantes. Porque hay mejor personas, que por ejemplo, a Michoacán se bien operar de esto del estado de México de lo que colinda con nosotros. El estado de Guerrero, Colima, etc. Por los servicios básicos que presta el IMMS. Entonces ahí radica la importancia del seguro social. Es eso. Por eso es la mejor institución de salud publica en el país. Y en muchos países de latina América. No solamente de México. Pero es un modelo, ya con muchos años de trabajo y con mucha experiencia. No falta pues de deficiencias y errores, pero no atribuibles apropiamente a la institución, sino porque somos muchos. Tu vas ahorita a cualquier institución de salud publica y ves largas filas para la medicina. Ves largas filas para una consulta. Pierdes todo un día. Y luego de la consulta del medico familiar luego te va a mandar a una especialidades, hasta doctor de 3 meses a ver al urólogo por ejemplo para riñón. Y tu tienes el dolor aquí. Es tanta gente. No podemos ponerte aquí, quitar el otro. y luego las intervenciones quirúrgicas. Es un gran reto para IMMS. Un gran reto de IMMS es la enorme cantidad de derechohabientes. Y si fuera un a mala institución, no

tenia derechohabientes. Se iban a otra. Eso es el meollo del asunto. Como ves? Haber, otra pregunta?
E: No, me parece bien. Muy bien. ¿Y cómo se llama el hospital con lo cual trabaja¿
J: Hospital General Regional Numero uno.

Interview with Aranza Zucanyon Nieto, Social Communications Manager (S.S.A) (H5)

E: Bueno, pues si me puedes decir tu nombre…
A: Sí, mi nombre es Aranza Zucayon Nieto, soy encargada de comunicación social en la secretaria de salud, en Michoacán.
E: ¿Y que nivel de educación tienes?
A: Soy licenciada de ciencia de información, por la Complutense de Madrid. Y master de la salud pública internacional. También por la complutense de Madrid.
E: ¿Y cuantos años tienes?
A: Tengo 36 años.
E: Y si me puedes describir un poco de tu trabajo en la secretaria de salud.
A: MI trabajo consiste en ser el enlace entre los medios de comunicación y la institución. Entonces por un lado ayudamos a los reporteros a encontrar a las personas con las que hablara cuando tienen alguna demanda de información concreta. Les dirigimos hacia el especialista que puede mejor saber del tema que están buscando. O el encargado del programa. Y por otro lado nosotros nos encargamos de difundir las actividades que hace la secretaria de salud. Tenemos contacto con las diferente áreas de la secretaria, sobre todo áreas de programas o los hospitales o el centro de salud de Morelia o algunos otros de otras ciudades. Y bueno, ellos nos informan de que los avances que están teniendo o que programas, o que cosas necesitan difundir. Por ejemplo difundimos mucho también, las jornadas académicas que hace hospitales a sus aniversarios. Y a través de ellas se [INAUDIBLE] de prensa, comunicados, reportajes, colaboramos. Pues, damos a conocer esas actividades. Hacemos también la coordinación general de comunicación social. Entonces es un trabajo mas pesados de gestión. Porque todos los empresos o material de difusión que se realiza la secretaria, debe de haber visto bueno, el gobierno del estado. Entonces hacemos esta gestión con ellos. Y a su vez también, ellos también, nos pide de nosotros información o materiales. Esos tipos de cosas.
E: Y con respecto a la diabetes si me puedes describir un poco sobre lo que has hecho o con periódicos o con programas.
A: De diabetes tenemos relación, por un lado con el… adentro del departamento de [INAUDIBLE] secretaria, esta el programa a la atención a la salud del adulto. Entonces lo del adulto y el anciano se ha quedado con nada mas. Y dentro de este programa se marca el programa de diabetes junto con hipertensión y la obesidad, deslipidemia según nosotros. Pero los mas fuertes ahí son diabetes e hipertensión. También tenemos contacto con médicos, endocrinólogos del hospital infantil, del hospital general, que son los mas importantes y el hospital de la mujer. Son los mas importantes aquí en Morelia. Porque además ellas a su vez a parte de trabajar en consultas, a veces por ejemplo han tenido platicas para el publico en el propio hospital. Y nosotros hemos ayudado en difundirlas. Tanto con convocando previamente para que apura al publico ,como el posteriormente, con un boletín en comunicado de esa platica. No tratar de difundirla a mas gente aparte a las que ya fueron. Y ellos además, este grupo de profesionales, se reúnen, y cada año celebran un congreso internacional de diabetes. Aquí en Morelia. Entonces, siempre desde que yo llegue, incluso antes de estar la secretaria, siempre

hemos apoyado en la difusión de este congreso. Para invitar, para darla a conocer a la comunidad medica y la que acudan. Y también pues, a la comunidad en general. Otra cosa hacemos así digamos, muy regularmente es cada 14 de noviembre, creo que es el día mundial de la diabetes, el grupo de auto ayuda celebra un evento en el que además invita a otros por su ayuda de otros regiones del estado. Suelen hacer una caminata por la calle principal. Y luego algún evento cultural con bailes y una degustación de lo que ellos también cocinan de sus clases. De alimentos que son saludables entre los diabéticos. Y pues, invitamos a los medios y damos difusión a esas actividades. Digamos que esas seria como las regulares, las de cada año, el congreso de la diabetes, el día mundial de la diabetes. En octubre se celebra también la semana del adulto mayor. Que es una semana que se celebra con la salud federal. Donde por supuesto intensifica las acciones de búsqueda de diabetes. Y todo eso. Y además, pues a lo largo del año y ya en una manera no tan programada, pues cuando surgen preguntas por parte de los medios referente a la diabetes les conducimos con uno de los doctores, o con alguien del programa. Les facilitamos información de cómo vamos en cuanto a detecciones. También de vez en cuando hacemos algún boletín que alguno comunicado de prensa preferido pues a las complicaciones de la diabetes, o como detectarlo. Pues son cosas mas generales. Ya no tienen así sus fechas fijas, pero sigamos dándole. Es un o de los programas de los quemas hemos hablado de los temas de salud. De los que más, lo que sigue siendo un problema, ¿no? Está ligado a otros problemas importantes en el estado como la insuficiencia renal. Tenemos ahí, un problema fuerte de la insuficiencia renal en el estado. Además apoyamos a la parte de transplante con difusión y eso.
E: ¿Y pues, a parte de los medios de que ya me hablaste suele usar otros: la radio, el Internet, la tele?
A: Cuando hablo de los medios nuestra difusión, nuestros comunicados de prensa, los enviamos a radios, televisiones, agencias, y periódicos. Los eventos igual los invitamos y entonces ellos captan imagen o captan sonido. Tenemos cierta dificultad para proporcionar imagen y sonido. Por falta de equipo. Cuando podemos conseguir un camágrafo de apoyo entonces sin problema difundimos imagines también. Pero no la tengo yo la cámara. Pero desde que llegue ya tenemos una cámara. Yo creo que este programa ya se solucionara en cuanto pues diga cassettes. Y por Internet subimos, bueno lo hace el departamento de informática. Los comunicados de prensa se suben a la pagina de Internet. Pero es la pagina institucional tanto como la del gobierno. En las dos figuras. Digamos que es el material fundamental de boletines. Hay otros materiales pero esos los hace ya la parte de promoción o nos los envían de México. Que son como carteles o folletos. Que quizás nosotros ahí nuestro trabajo es mas de gestión para que se produzcan, los tramites que hace falta. Pero ahí no entramos no al diseño, ni la decisión de cuantos. Porque esos son quien deciden quienes vas a recibir el programa.
E: Son intermediarios.
A: Sí, ahí seriamos intermediarios.
E: Y de esos eventos de que me hablaste, especialmente el congreso de diabetes, porque me entere de eso. ¿Qué efecto crees que tiene en la cuidad? O en los que sufre de la diabetes? También hasta los médicos?
A: YO creo que es un evento mas dirigida a la comunidad medica. O sea el efecto sobre los pacientes seria indirecto a través de la capacitación que tiene los médicos. Es un congreso, por lo que yo he visto, cada vez recibe mas gente. Será a lo mejor unas 500, 600 personas que las que pudieran acudir. No estoy muy segura. Algunas personas que son casi fijas en el programa. Que es el doctor Escandón.
E: El es de mi universidad. De Wake Forest. Ahí hice la licenciatura.

A: Sí, viene de Wake Forest y de, no se si de otra mas. Yo creo que ahí las amistades han sido muy beneficiosos porque permiten trae al estado. A la provincia. Generalmente, seguro que a México llega esta información. Pero aquí en la provincia, digamos los avances que se están dando en el mundo en este tema de la diabetes. Yo creo que esto es muy interesante porque permite a los médicos michoacanos, que a veces no tiene la facilidad para salir por sus tareas, por su tiempo, por dinero, etc. Les acerca a conocimiento esas novedades y a la larga puede influir en la diabetes. Y creo que también sirve como para ser encapiente la comunidad medica de la importancia que tiene este problema. Es un problema, un epidemia aquí en México. Y creo que hay que buscar el estrategia de comunicación permanente. Con momentos mas fuertes. Porque ya sabes que si siempre estas dando lo mismo, al final ni te escuchan. Yo creo que congreso de diabetes, el día mundial de diabetes son eventos que nos permite hacer encapie y bueno, luego ya seguir, de una manera mas puntual quizás a lo mejor con alguien que se interesa. Luego otro por aquí. Y vas haciendo diferente información sobre ello, ¿no? Este congreso ha de beneficiar, pero mas indirectamente.
E: Y si me parece que a los que se concierne sobe esto, y que escriben mucho sobre o los médicos, si se conciernen mucho. Y a ustedes también, y al IMMS. ¿Pero crees que la gente de a aquí se dan cuenta de la gravedad?
A: Mi percepción es muy personal…
E: Eso es lo que quiero.
A: Yo creo que como ya es un problema tan frecuente, es como algo mas que hay en la vida. O sea, ah sí pues mi abuela es diabética, pues sí mi madre es diabética, mi padre y tal. Es como algo que quizás se ve como algo mas que ocurrir en la vida. Que ocurre a mucha gente y que no sale fuera de lo normal. Por lo tanto, no suele dar la mayor importancia. Creo que también influye mucho que una gran parte de la población aquí en Michoacán, es recursos económicos. Y el acceso a los medicamentos es difícil. Y cuando falta a las instituciones de salud la gente las tiene que comparar. Y cuando las tienen que comprar y si los tiene que comprar, muchas veces no tienen dinero. Creo que esto puede influir en que la gente se deja llevar mas por remedios naturales o lo que te dice la vecina. Busca otras estrategias de ayuda, de apoyo a su enfermedad. Y además creo que también la dificultad de la diabetes es una enfermedad silenciosa. O sea que uno no se siente mal hasta que lo estas descompensado. Y los daños son poco a poco, en el tiempo, interno, tu no te das cuenta hasta que llevas en total. Entonces creo que esto influye en que no lo veas como un problema grave. Seguramente la gente aquí vive problemas muchos más graves en el día a día. Y a los que debe dar una solución antes. Y no solamente de salud. Problemas económicos. Pues realmente la gente…pues esto es mi percepción personal.
E: No, esto es lo que quiero. ¿Y como organización de la secretaria de salud, tiene un énfasis en una cosa u otra¿ ¿Cómo, más bien a la detección, más bien a la prevención, más bien al tratamiento? ¿Te parece?
A: Yo creo que nuestro énfasis esta dado en la detección. Se trabaja mucho en encuestas y factores de riesgo y después en las pruebas de detección. En todas nuestras ferias de salud, aunque no sean de diabetes, en todas hay una detección de diabetes, hay detección de peso y talla. Es uno de los componentes en las ferias de salud aunque sea de otra cosa, se mete. Y es una forma también de acercar a la gente en conocimiento en esta enfermedad. Porque también tenemos una población que lo tiene como un dice índices de lecturas muy altos. No es un comedia para picarnos. No es mas en cara a cara. Entonces esas ferias nos a dar a conoces a esta enfermedad. Y ya que uno se encuentra con ella, y ya ahorita me lo hago, y ahorita veo si soy o no soy, no? Y el tratamiento, creo que también se trabaja en ello. Pero a lo largo de los años, no

se como estamos ahora, porque ahí, sí, tengo una laguna de 10 meses. Te puedo decir que hace un año para atrás, unas de las dificultades que tenia la secretaria de salud era en recursos económicos para comprar medicamentos. Entonces eso, aunque tu les puedas dar el mejor conocimiento medico que tengas en tu personal, si no tiene medicamento y no lo puede conseguir pues, bueno esto se queda a medias. Y no es que sea culpa de la secretaria, o culpa de la gente, sino esto son las consecuencias de este país.
E: Y como una…bueno, ya no va seguido pero… ¿Ahí en el centro de salud, cuanto cuestan los servicios?
A: Bueno, esos son muy baratos, porque además ahí hay como diferentes modalidades. La consulta creo recuerdar que es 10 pesos, 20 pesos, algo así. Sí la consulta es barata y sí incluye el medicamento. El problema es que muchas veces el medicamento no es disponible. No lo hay.
E: Sí me di cuenta. Estaba en un reunión, y dijeron que no habia.
A: Creo que ahorita han cambiado el sistema. Y ahora es con unas farmacias privadas o sea que llevan una notificación entonces esto ya tiene que surtir el medicamento. Pero desconozco si hay diabéticos en este esquema. Las personas que están afiliados al seguro popular no pagan nada en el momento de acudir la consulta. No recuerdo ahora si la diabetes esta incluido. O creo que el básico sí, y luego ya a las complicaciones, no. En el catalogo de servicios. Se encadece ya pues los que tienen insuficiencia renal. Tenemos un nivel de hemodiálisis, pero chiquita. No tenemos para toda la capacitada que tenemos. Para el demanda que tenemos. Y aunque es mas barato el precio aquí, por algunas gestiones que hicieron, pero de todas maneras hay que pagarlo, no? Entonces esto..me he perdido.
E: ¿Y de donde viene este dinero para ustedes y para esto centros, por que me imagino que fluye desde dentro la secretaria de salud hasta ellos?
A: Sí. Ah, me has preguntado cuanto cuestan las consultas. Los servicios que tiene realmente los que tiene del salud son baratos. El problema es que cuando no hay medicamento y la gente lo tiene que comprar. Y mas en una enfermedad que estará por vida. El dinero proviene del presupuesto, nosotros decimos dos fuentes de presupuesto, el estatal y el federal. El federal es el mas importante. Y dentro del federal hay una parte que digamos que es el presupuesto ordinario, que es el que habia antes del seguro popular. Y el seguro popular que también tiene su reglas de aplicación. Todavía tenemos cuotas de recuperación. Estos 10 pesos o 20 pesos que se cobran en la consulta, bueno, esos son cuotas que ayudan a la operación de los servicios. No se si a veces pagan a sus corrientes o mejor una compra de algún determinado insumo. Hay otro que los medicamentos vienen, o sea los medicamentos no los compra el centro de salud. Los compra la secretaria de salud y los distribuya a los centros de salud y a los hospitales. Ahora esta hasta la esquema nueva de las farmacias que bueno, creo que es una licitación y esa farmacias es la que tiene que distribuir a las unidades de salud.
E: ¿Y cuales son los pacientes que van ahí? Si me puedes describir su…
A: Perfil.
E: Sí, su perfil.
A: Pues mira, fundamentalmente, nuestra población es una población que no tiene seguro social. Fundamentalmente. Entonces, ya ves que en México hay una esquema fragmentada de servicios de salud. Esta el IMMS, que es una seguridad social para trabajadores del sector privado, el ISSTE que es una seguridad social para los trabajadores del sector publico, luego hay otras mas pequeñas, pero los mas importantes son el IMMS ISSTE y la Secretaria de Salud. Y su vez la secretaria de salud desde el año 2003 esta en una proceso de transición. Anteriormente atendía

solamente a las personas que no tenia seguridad social. Aunque en realidad también viene personas tienen personas con seguridad social.
E: ¿Se puede?
A: Sí, porque es muy difícil tu comprobar que una persona tiene algo. A veces, sí se busca la manera de que si el paciente tiene seguro, se atiende en su servicio. Pero bueno, la realidad es que a veces viene la gente y los atendemos igual. No estás pidiendo la creencia a nadie. Es más el cuestión del hospital, pero en la secretaria de salud, sí. Es un porcentaje que varia, nosotros ni conozco la cifra. Nuestra población, es población abierta te digo, pues son personas sobre todo encargadas a la economía informal. O campesinos también, en las áreas rurales. También dentro del IMMS tiene IMMS Oportunidades de clínicas rurales, que atienden también a la población rural. Es una manera de fortalecer esa atención en las áreas rurales. Pero fundamentalmente, nuestra población es de clase popular, clase baja, en cuanto al económico. Nos aumenta la demanda cuando llega una crisis económica. Generalmente, porque mucha gente pierden empleo y pierden su seguro social. Y bueno, y ahora con el seguro popular...El seguro popular asegura gente que no tiene IMMS e ISSTE. Claro, no todo el mundo es de esta clase baja o de economía informal, porque hay empresas que no aseguran a sus empleos. Hacen fraude. Y entonces, pues esos, vienen con nosotros. Solo me cuesta un caso porque una amiga mía esta trabajando, y es una licenciada universitaria y ahorita se va a acabar su seguro.
E: ¿Y aquí en Morelia que crees que es la mejor manera para la gente que quiere buscar información, sobre la enfermedad de diabetes¿ ¿Donde sería?
A: Yo creo que las unidades de salud. Las personas que quisieran encontrar puede acudir en el centro de salud de Morelia. Donde tenemos el equipo del doctor Márquez. Hay médicos, enfermeras para sociales, para ayuda. Realmente es un muy buen recurso para tener una información muy personalizada. Muy adaptada a las soluciones de cada quien. También los hospitales, ya en el mujer o el civil o el infantil, que también ahí tenemos un endocrinólogo que atiene a los niños con diabetes. Digamos para una cosa muy personal. En cuanto a información mas general, nosotros tenemos la información que difundimos a través de los medios de comunicación. Eso igual es la información que mas bien te encuentra. Hemos difundida, hay una pagina de Internet. Creo que se llama todosobrediabetes.org. Eso es otro de los recursos que se puede usar para informarse. Y no sé si siga funcionando, pero que sí en el boulevard de García de León hay un centro privado, que se dedica a la investigación.
E: ¿Cual? ¿La CEYAMED?
A: No me acuerdo de su nombre.
E: Centro de educación y atención a la diabetes.
A: algo, así. Sí. Yo fui cuando lo abrieron, yo era reportera, así que les ayude descubrir la nota. O estaba ya ahí y les ayude difundirlo. Pero ya no he sabido como siguen trabajando.
E: Sí, todavía siguen. Pero es privado. Así que me imagino que es más caro, ¿no?
A: Sí, probablemente.
E: Les tengo que preguntar cuanto cuestan los servicios. Por ahí ya pasé. ¿Y que sentimientos crees que la gente moreliana tiene de la diabetes? Pensamientos, sentimientos y luego estos mitos que salen de la tradición.
A: Mira, esta pregunta me resulta mas difícil de contestar, porque yo aquí no tengo familiares. Entonces, me resulta mas difícil saber, digamos a un nivel familia, vecinos que puede pensar la gente sobre la diabetes. Te puedo hablar de casos personales que he conocido de un amigo que le diagnosticaron la diabetes. Realmente para el fue un golpe sicológico porque esta persona además es medico, entonces sabe de que se trata. No se dedica a la medicina, se dedica a la

comunicación, no ejerce la medicina, pero sí sabe. Para él se que para el fue una cosa muy importante, que ha ido superando. Cambio sus hábitos y ahorita pues sí es muy de su propia salud, de su vida, de sus hábitos y todo esto. Pero creo que esta gente no es…
E: El típico.
A: El típico
E: Es medico además.
A: Sí, además digo por su perfil, no es el típico. He oído mucho que la gente atribuye el surtimiento de la diabetes a los sustos, a los disgustos. Ahí desconozco si hay alguna razón que lo justifica desde punto de vista fisiológico que pudieras encadenar. O simplemente es cuando te das cuenta. No sé. Hay personas que…tengo algunos conocidos que tampoco le da mucha importancia a ello. No se cuidan. Y creo que la gente vive con ello como algo mas, a veces. Pero no como algo que lo consideran no tanto como una enfermedad. Es como una condición. Pero es una sensación que me da…realmente no te puedo contestar mucho ahí. Porque yo vengo de otra cultura. O sea que mi lectura de esos tipos de cosas es muy diferente. Por ejemplo para mi la diabetes era algo como muy extraordinario. Porque en todo mi entorno familiar solo un amigo de mis padres era diabético. Y se cuidaba muchísimo. Para él es la combinación, pero era especial. Y finalmente se murió del encemia. O sea nada que ver. Pero bueno, la diabetes no le mató. Y era como algo muy extraordinario y se cuidaba mucho tal. Tengo otra amiga en España que es diabética con insulina, va con su bomba y todo eso. Realmente ahí veo que si cuando uno es diabético, como que su vida ya cambia mucho mas. Y se hacen mucho mas concientes. Más cuidadosos de buscar de retrasar las complicaciones. Y aquí me da la sensación de que es un poco mas asumido como una parte de algo que te puede pasar en la vida, como te puedes quedar sin trabajo, como te puedes, quedar cojo, o algo así, no se. Hay cierto fatalismo en Mexicanos de que la cosas te pueden ir mal, y lo asumes y lo aceptas y sigues por alegría.
E: ¿Y una cosa más, sí con respecto a la secretaria de salud, si lo abordan de una manera que a enfermedad es más una cosa individual o más de la sociedad? ¿Más problema de la salud publica o de cada uno?
A: Yo creo que las dos vertientes. O sea, digamos desde el punto de vista de salud publica de los programas, etc. Creo que sí ahí hay en la secretaria una gran consciencia que es un problema serio. Desde el punto de vista epidemiológico, ¿no? Por el porcentaje de la gente que afecta, por las consecuencias que tiene en general a la población, en la economía, en la gente y del país. Porque es una de las vías para llegar a gasto catastróficos en pobrezerte. En los propios servicios de salud la carga presupone…creo que es a primera causa de amputaciones no traumáticas. Es la diabetes. Y sí es relativamente frecuente en el hospital. Desde luego creo que la 60% de la insuficiencia renal están atribuidos a la diabetes. O sea, sí, es un problema de salud pública. Y creo que ya en lo que es el medico, el clínico, el que esta en palpido cañón, en la consulta tienen un abordaje pues, porque yo a esos a los endocrinólogos conozco, y son conscientes que sí es un problema serio y grave desde el punto de vista de salud publica. Pero tiene el enfoque individual con uno de sus pacientes. Yo creo que sí aborda a los dos, los dos vertientes. Desde luego, por ejemplo creo que en cuanto hay información, digamos que puede haber en el ambiente. Mi percepción es que ha mas información en México al menos en este ambiente de Michoacán sobre la diabetes, de lo que pudiera haber en España. En España lo veo que vas mas por vías de instituciones privadas, empresas, laboratorios y son los que mas que hablan de eso. Ha sido creciente en los últimos años. Yo me vine en el 2000 y entonces no nunca habia oído tantas noticias de salud como ciudadana. Que llegué aquí, y aquí sí. Sí se hacen llegar a la gente. El cáncer, la diabetes, esos tipos de problema. En España los problemas de salud es la anorexia, la

infertilidad, son los que están en los medios y lo que se hablan, son esos tipos de cosas. Las adicciones. Y aquí estos dos temas, y este de la diabetes es muy importante. Ahora ya en España empieza de hablar, se empieza a ver también alli. Que ya no es el tipo diabetes 1, es el tipo 2.

Interview with Carmina Martina González, (P1)

E: Para empezar si me puede decir su nombre, su edad, y en que trabaja?
C: Yo me llamo, Carmina Martina González. Tengo 48 años. Y trabajo aquí en el grupo. Yo ayudo. Tengo ya tres grupos yo que dependen del Dr. Márquez. Los tres son puestos por el centro de salud. Esto, uno se llama diversión física, templo del niño de salud, de aquí de Morelia. Ahí les doy ejercicios también igual. Que se componen de un calentamiento, una caminata, un baile, y un relajamiento.
E: ¿Y usted es de Morelia?
C: Sí, yo soy de Morelia. Yo soy de aquí cerca, de Santa Ana Maya.
E: ¿Y está casada?
C: Sí.
E: ¿Tiene hijos?
C: Sí estoy casada, tengo siete hijos.
E: ¿Y que nivel de educación tiene usted?
C: Segundaria. Nada mas la segundaria.
E: ¿Y sí, usted es diabética?
C: Yo soy diabética.
E: ¿Hace cuanto tiempo?
C: Hace aproximadamente 15 años? aquí en el grupo tengo 11 años.
E: Wow. Que bien, ¿no?
C: Sí. Por eso soy una de estas que mas le ayuda.
E: ¿Y como se enteró que tenía la diabetes¿
C: Yo me enteré, porque me entro una enfermedad que ahora sé, que se llama, aquel entonces no sabia cómo se llamaba, depresión. Un ansiedad, no podía dormir, o sea me sentía muy mal, mucho estrés. Pero no sabia como se llamaba. Entonces, yo fui con una doctora. Ahí por mi casa, no vine inmediatamente al centro de salud. Pero esa doctora trabaja aquí en el centro de salud. Y me dijo que viniera mejor aquí al centro de salud, me vio la doctora. No me acuerdo muy bien la doctora que me vio la primera vez. Y me dijo, "tienes que ir a los ejercicios, porque eres muy joven para que ya tengas esta enfermedad." Te puedo dar el medicamento, tu lo vas a comparar, pero no es el chiste, no es el caso. Porque cinco años te garantizo bien con el medicamento. Después de cinco años, entiéndeme bien, no te vas a morir, pero vienen las complicaciones. Viene las complicaciones que ya vas a empezar a sufrir ya de algunas complicaciones de la diabetes. Entonces, vete porque yo era muy, realmente yo no hacia ejercicios, yo decía que no tenia mucho que hacer. Entonces le digo yo "bueno, voy" y lo pensé. Todavía como unos 15 días. Y me vine a probar. Y pues hasta la fecha 11 años tengo en el grupo.
E: ¿Y cuanto a menudo viene?
C: Venimos…mira todo lo que tengo aquí. Porque yo el lunes y miércoles estoy en el grupo del 5 de febrero, que es el grupo del centro de salud. El módulo ocho, del centro de salud. El martes, jueves y viernes el del niño de salud. Y aquí en centro de salud vengo martes, jueves y sábados. Que martes y jueves yo aquí, vengo de 10-11, allá me voy rapidito. Ahorita estamos libre hasta

semana de vacaciones, porque ocuparon los templos, los salones. Pero yo me voy rápido. En media hora llego yo allá. A las 11:30 me esperan allá para darles de 11:30-12:30.
E: Que activa.
C: Y así ando. ¿Cómo lo ves? Si llego a mi casa y sígala con el quehacer. Pero me he sentido muy bien.
E: ¿Sí?
C: Muy bien.
E: Pues, bien. ¿Y que le causo la diabetes?
C: Pues, probablemente la obesidad. Lo mas seguro la obesidad. Una. O sea ahorita vengo muchos factores. Porque mi obesidad, que me casé muy chica, 15 años. Tuve bebe. Y aquí, obesa yo. De alli para acá, ya porque ya empezaba. Pero uno si saber ni nada. Esto que hacer las personas que saben eso es lo que causa esto. Y mi familia, mi familia de mi mama, toda ha acabado con diabetes.
E: Así que, ¿sabías de la diabetes antes? ¿O sabía, que era susceptible?
C: No.
E: ¿No?
C: No. Hasta que yo empecé a venir aquí. Si. Tantito antes, empecé a ver a mi mama enferma. Y la ignorancia. A veces hace muchos errores, cometimos muchos errores, como ignorancia. Porque mi mama, nada mas empezó, que mucho hacer, que mucho hacer. Agua, y agua de limon, y que unas rayitos de sal para que te quita la sed. Y no la atendimos definitivamente. Muy a temprana edad tuvo que estar con la insulina, porque se le acabo la insulina, por completo. Pues, aquí yo aprendí mucho. Aprendí mucho porque anterior mente no habia los otros grupos. Nada más, en este. Nos íbamos el lunes a nutrición, el martes aquí ejercicios, el miércoles clase de diabetes, el jueves ejercicio, el viernes tenemos un club de cada mes. Un región del club , le llamábamos, y salíamos a ver los museos.
E: Que bien.
C: Y ya este ahora ya no, porque ya cambiaron las cosas, bueno para mí. A lo mejor la de mas personas siguen viniendo a todo. Pero no voy ahora haciendo a puro ejercicios. Y les organizamos paseos, también nos vamos al bañarlo, de vez en cuando. Que ha sido dos veces al año, porque no dan permiso que salgan tan seguidos los médicos. Trabajo social y somos en la compañía para poder ayudar a tanta gente. Pues al estar pendiente. Pero el programa del centro de salud esta muy, muy bueno.
E: ¿Y solo ha venido aquí?
C: Sí, al centro de salud.
E: Así que bien, no?
C: Sí, bien.
E: ¿Y cuando se entero que tenia la diabetes, buscaba información?
C: Sí.
E: ¿En donde?
C: Aquí en el Centro de Salud. Porque te digo, que cuando me dijo la doctora, “trae mil de azúcar”. Pero, no me explicó. Entonces dije, “mil de azúcar, cosa de que será esto?” Y no lo daba la mayor importancia, me seguí sintiendo mal y eso. Hasta que vine aquí, la doctora me explico, con mi azúcar, que lo tenia levantado, y eso me dijo la doctora. Y de ahí para acá, desde me mando al grupo, venia al grupo, me puse en manos de doctor Márquez. Empecé con mis consultas. El me sacó muchas dudas. El me ayudo mucho en mi vida porque yo tenia muchas dudas sobre, por ejemplo unos ganglios que traía inflamados. Y eso decimos es cáncer, porque

luego uno se va para lo mas… Y este es cáncer. Yo lloraba. No quería decirle nada al medico. Porque ya le dije al medico. Y el medico se rió de mi. Porque dijo que eran unas mamarias sementales, algo así. Dice, "Carmina, ¿pero que pasa con lo que te he dicho?" Ya terminé de decir de, salí de ese [inaudible] que tenia. Entonces le agarre mucha confianza a el. Y le dije otro problema que traía, y para mí yo el era lo máximo. Y con él he buscado toda la información de diabetes. Aun para mi familia, por ejemplo, para mi mama, un sobrino, que tiene ya la diabetes juvenil porque el es chico. también con el, me enfoque a hacerle yo preguntas. Para que cuando uno se necesita ayuda.
E: ¿Y viene acá su familia también?
C: No, mi mama, no, porque mi mama, tiene seguro. Ella va al seguro. Si. Y tú sabes también lo que me gusta, que le den por ejemplo también el medicamento. Si. O sea económico también. Ella va al seguro. Y también mi sobrinito va al seguro. Y yo como no tengo seguro, yo estoy aquí. Y ahorita yo pienso que aunque yo llegara tener seguro, yo seguiría aquí.
E: ¿Ya te gusta aquí?
C: Sí, sí, sí.
E: ¿Y ellos van a ejercicios también?
C: El niño juega mucho al fútbol. Es muy activo. El es muy activo. Mi mama ya es una persona grande y tiene cosas en sus pies y allá no puede…si puede, pero ya no quiere ejercitarlo mucho porque le duelen. No quiere. Yo le digo que aunque te duelan un ratito, pero con la caminadita, se te va. Pero ya es una persona grande y ya ahora. Así que si dice que es negro, es negro, aunque sea blanco.
E: Así que, sí le afecta mucho a la vida cotidiana a su familia el ser diabético.
C: Pues, sí. Con mi mama con sus dolores. Le riñera mucho.
E: Y cual es el aspecto más difícil o frustrante de la diabetes, según usted?
C: Para mi sería frustrante sería que me dijera "el riñón te está fallando". No sé, riñón o corazón. Te digo porque mi hermana ya se falleció de la diabetes. Y su corazón se hizo grande, se le taparon válvulas. A causa de eso. Yo se, y estoy consciente que es a causa de la diabetes. Y de los cuidados que no tenemos. Porque tenemos una manera de sostenernos la vida. Eso es el principal detector que tenemos nosotros.
E: Y aquí en Morelia, que cree que es la opinión de la gente de la diabetes en general?
C: Pues hay muchísima gente aquí diabética, muchísima. Y me da tristeza ver, me da tristeza pero me pongo en las guardias, porque yo ya pase por ahí. Cuando a veces me toca consulta y veo las personas que salen llorando. Desesperadas. ¿Por qué? Porque se les informo que tiene esa enfermedad. Y a veces me toca platicar con ellas, o si tengo la oportunidad acercármeles. Tómele con calma, es una enfermedad que se puede control y que podemos vivir muchos años con ella sabiéndolo controlar. Porque vamos a ver el lo de esta manera, el cáncer. El cáncer es una enfermedad traicionera. Ay, yo también yo le digo a la diabetes que es traicionera. Porque o la traemos arriba ya la traemos abajo. Para mi es una enfermedad traicionera. Pero mas que el cáncer, no, eh. Mas que el cáncer, no. Por que si te lo controlas, ahí vas. Ay, llega el día en que, haces tus destraigos por dentro, pero si nos cuidamos vamos a durar mucho tiempo. Y tenemos un ejemplo bien grande con el doctor Márquez. Una persona de 86 años. No se cuanto tiempo tenga diabético, pero siempre ha sido diabético. Tan bien se fue su tiempo. Y tenemos un buen ejemplo con él. Y también la doctora Cortez. Pero el doctor Márquez ha sido mas ordenado en su vida. Mas ordenado en su vida, porque se ve. Y lo que se ve, no se pregunta. Cuando empezamos con la clase, luego empezaba cuando yo iba, porque te digo ahora que tengo tiempo que ya no puedo ir, empezaba, el doctor "es que están bienes?" y "yo, no doctor". Y yo cuando hablamos,

también les decía, pero lo que se ve no se pregunta mi hija. Pero si nos esta viendo el y no habia modo de cómo estamos, y dice, "no cómeles estas gorditas de aire". Tenemos una forma. Y decía que tiene manera desordenada para comer. Y decían las personas, este, yo no doctor, yo si como lo que usted me dice." Y yo me acercaba y le decía pero si el doctor te está viendo. Porque estamos bien gorditos. Cómo le vamos a decir que no. Sí, pero, ya te digo, eso es el único que hay mucha gente que cuando lo empieza a conocer se asusta. Se deprime. Se deprime mucho. Y no tuve la oportunidad de deprimirme a lo mejor porque caí en buenas manos. El primer día que vine con él, no se me olvida porque te digo que yo traía el problema de la depresión que ahora ya se que se llama la depresión En aquel entonces yo decía, ay siento como que soy y como que no soy. Ay, yo me siento desesperada. Quisiera hasta no se que, correr. Ay me quiero volver hasta loca. Entonces, ahora se que ya es depresión. Entonces cuando iba con el, entonces me empieza a preguntar y yo decía, yo le voy a decir esto, y esto no. O sea yo iba casi seleccionado lo que le iba a decir y lo que no le iba a decir. Y llegue ahí yo con el, y solté hasta todo, todo. Pero cuando yo me acorde, yo estaba en un mar rellanto. Llore, llore y llore y me dice el doctor, "déjame que llore, que llore hasta que se canse. Pero yo descansé. Y de ahí para acá, no he vuelto a llorar. Estoy tranquila. Si hay ratitos que se suelta uno, porque es una enfermedad que a veces estas bien y al ratito…
E: Pero a mi me parece que vas estupendamente.
C: Sí. Así me siento yo. Que de peso no he podido bajar. Yo tengo 11 años aquí. Baje, porque llegué pesando 105 kilos. Ahorita estoy a 97, 98.Ya de ahí no puedo bajar. Y si me hago mi dieta, y si hago la dieta, me baja el azúcar. Y me siento mas mal.
E: Pues, muchas gracias.

Interviews with Autor González (P2) and Celia Ortíz (P3)

E: Primero, si me puede decir su nombre, su edad.
A: Autor González, 57 años.
E: ¿Y es usted de Morelia?
A: Sí.
E: ¿Y tienen hijos?
A: Sí.
E: ¿Cuantos?
A: Cuatro.
E: ¿Y qué es el trabajo que hace usted?
A: Soy contratista
E: ¿Contratista de?
A: En telefonía.
E: ¿Y cual es el nivel de educación más alto que tiene?
A: Preparatoria, pues.
E: ¿Y siempre ha venido aquí para la diabetes?
A: Pues, últimamente, nada más. Tiene poco.
C: Apenas, empezamos de venir.
E: ¿Cuanto tiempo hace?
A: Un mes.
E: ¿Cuando se enteró de la diabetes cómo llegó a encontrar este lugar.
A: Me enteré hace 3 años. Y este lugar lo encontró ella pasando por aquí en frente.

E: ¿Y antes donde iba para tratar la diabetes?
A: Tenemos un doctor en el centro de salud.
E: ¿Y sí, cree que es tener acceso a servicios para tratar?
A: Aquí en Morelia, sí.
E: ¿Y cuando se entero de la diabetes, habia más formas que buscaba información a parte de ver edificios?
A: Sí lo documentamos más. Folletos…
C: Internet.
A: Sí Internet.
E: Y¿ de sitios Web generales o de sitios de Morelia?
A: Pues Internet por general.
E: ¿Y eso le ayudó?
A: Sí.
C: A conocer un poco de la enfermedad. Porque uno desconoce por eso se descuida tanto.
E: Claro. ¿Y qué información sacaba al final? ¿De la más importante de qué se acuerda?
A: El cuidado de la alimentación. La de alimentación y del medicamento. Que más o menos deberíamos de llevar. Sí eso era lo más importante.
C: Algo no se hacía antes es el ejercicio. Y que es básico el ejercicio. Y que nos cuesta entenderlo porque no queremos hacerlo.
E: A ver. ¿Y conocía mucho de la diabetes antes de que se enteró?
C: No.
A: No. Pues de la diabetes casi no sabíamos nada. Antes de que me la declararon. Entonces fue cuando empecé a investigar. Y a preguntar. Desde entonces.
E: ¿Y cuando empezó a enterarse de todo eso que creía pues, que le podría llegar a pasar, con respecto a tu físico o tu vida?
A: ¿Qué podría pasar? Pues, que me enfermara más grave. Menos salud para mí. Entonces fue por eso que empezamos a cuidarnos más.
E: ¿Con cuanta dificultad cree que es vivir con la diabetes?
A: Pues es difícil, porque sí es un cambio muy drástico. De a como estar acostumbrado a su alimentación. A cómo la tienes que llevar cuando ya estás enfermo.
E: ¿Y sobre todo lo más difícil?
A: Para mí lo más difícil ha sido eso. Por el cambio de, pues mi cambio de alimentación. Mi manera de vivir ha sido diferente.
E: ¿Y pues, aquí tiene su esposa, así que sí le ayuda, como le ayuda?
A: No, ella es el apoyo total mío. O sea, ella es la que me hace la alimentación, me cuida mis horas de comida, mis medicinas. Porque pues dentro del trabajo es más descuidar. Más se me olvida y no puede. Y ella siempre me esta recordando que es lo que tengo que comer, que es lo que tengo que tomar.
C: Y decirle ya párale porque el quiere comer.
E: Y, pues, ¿qué es lo que causa la diabetes?
A: La mala alimentación sobre todo. Y la herencia. Yo mis padres eran diabéticos, así que la heredé.
E: ¿Y para usted que tiene la más importancias de la diabetes, el ejercicio, el medicamento?
A: Pues el ejercicio es ahora el más importante.
E: ¿Y ahora qué van para el ejercicio?

A: Ahora el ejercicio que hacemos es muy leve. Pura caminata es lo que hago yo. NO más camino. Tuve un accidente y ando un poco lastimada de la columna, entonces es lo único que puedo hacer ahorita…
C: Muy lastimada.
A: Más que caminar.
E: ¿Todos los días?
A: Sí trato, hacer todos los días.
E: ¿Y qué es lo que le preocupa lo más sobre la enfermedad?
A: Pues, que me descuide yo y que me avance más rápido y más terriblemente.
C: Y que no podemos controlarla. Por ejemplo ahorita no lo entendemos bien, verdad? Cambiamos de medicamento y no se le entiende cómo.
E: ¿Y sí han vendido a los cursos aquí que da?
A: A cursos no. Consultas nada más.
C: Tenemos poco con el doctor, la verdad. Entonces dice que va a haber cursos.
E: ¿Y qué es lo que le frustra sobre la enfermedad?
A: Me limita. Me limita de lo que estoy acostumbrado. Y me limita sobre todo en el alimentación. Como te digo, tantos años de comer mal, pero sabroso. Ahora ya es muy diferente.
C: A veces peleamos todavía por eso.
Ortiz: Se puede comer de todo. La única clave es las cantidades. Bueno, yo siempre les digo que es la oportunidad para llevar una vida más sana. Porque si hubiera llevado una vida más sana antes, no hubiera de salido la obesidad y quizás hubiera salido la diabetes.
C: Pero como el hubiera no existe, entonces de aquí en adelante tenemos que entender verdad. Nada más las cantidades que nos dieron la dieta son pequeñísimas. Pues, no?
O: Están acostumbrado al comer en exceso. Sí. Entonces, ahorita todavía sí quiere ¿? O ya no?
A: Ya no. Ahorita, ya casi no.
C: Ya casi no. Ya peleamos menos. Pero luego…a veces
E: Pues una pregunta más. ¿Cómo creen que ven los morelianos la enfermedad aquí en Morelia? Que dirían?
C: Pocos ponen atención en eso. Poca gente tiene el conocimiento. Muchas veces dicen, y eso es no conocer. Muchas veces dicen hay que bajar de peso, no ya dejé del pan. Pero como uno mucho carne, come uno mucho la batangas y no agarrar las verduras. Entonces el que te diga baja de peso, si no te dan el conocimiento, nada más te bajas. Eso es lo que nos ha pasado.
A: Sí, lo que pasa es que, como te diré, mientras no estás enfermo, no te importa nada. Cuando ya estás enfermo es cuando quieres prevenir y ya quieres hacer ejercicio y ya quieres dejar de comer. Y no hay medicina preventiva…
C: Sí la hay.
A:…sino hay correctiva. Para la mayoría de la gente no lo haga.
O: Sí luego es correctiva
C: Y mucha gente no escucha, tenemos a los hijos que no escuchan. No escuchan. Estamos viendo e hijo mira, previene esto que no pasa lo mismo. Se voltean y será, lo mismo. Entonces ese detalle es un momento en lo que escuchamos y cuando nos damos cuenta estamos dentro de la enfermedad.
E: Pues, hay que enfocarse más en la prevención.
A: Sí, porque en muchos lados, por ejemplo en la televisión, en cosas te lo dan así superficial. Sí lo quieres tomar lo tomas. Pero si no estás enfermo, no lo tomas. Lo tomas cuando ya estás enfermo. Cuando ya tienes que empezar a atenderle para no tener complicaciones adelante. Pero

antes, si quien te dice no te engordes porque te va a dar diabetes o, ahí no lo sientes. Y ya te dio ahora a cuidarte. Entonces cuando cambian las cosas paramos.
C: Dice, yo estoy gordita, pero estoy contento. A ver, que mentalidad es esa? Y por ejemplo nosotros de grande ya no es fácil bajar de peso.
O: Pues, hay que dejar de eso.
C: Pues, sí, pero para mí…Porque no puedo. Quiero llegar a tal peso, yo todavía no poder.
E: Pues, muchas gracias, no quiero tomar más de su tiempo.
[interview ended, then conversation began again, so I turned the recorder back on]
C: O sea por tanto lo traje porque no quería, verdad.
E: ¿Ah, sí?
C: No quiere.
A: Entonces que, no tengo tiempo.
C: Dinero que no tiene uno a veces.
A: Mi trabajo normalmente no es aquí en Morelia, sino en los alrededores. Traigo gente fuera, y tengo que andar con ellos. Pero ahorita me tuve que venir, para ir a la consulta y mañana otra vez regresar.
C: Por eso a veces no llega.
A: Son problemas no?
O: Hay que organizarse para poderse estar bien. Para controlar su diabetes. Que es el numero uno.
A: Sí, exactamente. Pero le voy a poner un caso. Hay lugares en lo que llegamos y no hay ni de comer. Llegamos a poblaciones en que no hay que comer, y ¿qué hacemos?
O: Y ahí hay una solución, y es espérate.
C: Sí, pero dos tres días?
A: Por ejemplo, voy a Lázaro Cardenas, pero de Lázaro me dice que vas a ir a un rancho poblano y tal y ahí trabajas durante 5 días. A un distancia de 100km. ¿Ahí que? ¿No hay un lugar en que encuentre!
O: Hay pescado. Hay pollo. Hay frijoles.
A: Mientras eso esperan y tal. Pero mira que a veces no. O sea de veras yo he andado en poblaciones y no hay que comer.
O: Acuérdese que puede comer de todo. La clave no mas es la cantidad. En otras partes hay que comer. Creo que de eso que hay que comer, hay que escoger la más saludable.
[a silence, then laughter]
E: ¿Y esos es lo difícil, verdad?
A: Fuimos a un pueblito que esta delante de Patzingan. Y ahí la gente no más guisa con manteca. Pura manteca. Y la comida manteca y el calor hombre, no se antoja nada.
C: Todo se enfermaron, todos!
A: Entonces aguantamos hasta la tarde que llegaba una señora a vender sandias. Pero nada más las tardes. Y pues eso es lo que habia de comer. Compramos una o dos sandias.
O: Pues hay otra opción. Infórmese a donde va. Y adonde va, cómprese también sus cosas. Y a veces a vas a irse…
C: Pero no le da tiempo de guisar.
O: No, que lo haga el. Que dice a la persona, que le diga a la persona, mira, quiero que me guises con este aceite, quiero que me hagas estás cosas así. Eso sí puede encontrar. Claro es un poquito más, laboroso.

A: Es muy difícil. Desde ahorita como están las cosas desconfían mucho de gente extraña que llega, ven que estamos trabajando y tal pero, a veces no un vaso de agua, te lo dan. Y yo lo entiendo.
O: Entonces en estos casos tiene que llevarse sus…
A: Sí, podemos llevar.
C: Sí lo más que puede. Pero después tiene que comer el ahí todo de eso. Todos los señores. Todas las semanas corridas digamos.
A: A veces hay miseria del malpasarse y mejor nos apuramos y regresamos a donde hay que comer. Pero cuando llegamos procuramos para alimentarnos bien porque ya veníamos mal pasados.
C: Y ahí están los problemas y no te bajas.
A: Pues cuando nos toca ciudades grandes no hay problema. Ahí sí, no hay problema. Le busca uno que sea lo que haiga ¿verdad? Lo que haiga, y eso va y come tortas, tacos, pollos, que es lo más común.
C: Pues, OK joven, entonces.
E: Sí, muchas gracias.

Interview with Ana Figueroa (P6)

E: ¿Y su hermana cuanto tiempo lleva con la diabetes?
F: Digo como 9 años.
E: ¿Y usted la ayuda?
F: Yo, soy la que soy con ella. nada mas tenemos. Soy su hermana, y todo lo que sea para ayuda. Yo no tengo mas ayuda. Yo trabajo también para mantenernos. Y tengo mi casita. Que mi marido me dejo.
E: ¿Y cómo la ayuda a su hermana?
F: Le llevo la medicina, también al doctor cuando es necesario. Nada mas, este doctor no le gusta nada. Me gusta mas el doctor que tenemos porque el hace muchos comprensiones. Y nos resulta esto payaso. ¡Ah no!
E: ¿Y siempre han venido aquí?
F: Sí, aquí venimos, y tenemos nuestro doctor conocido y el sabe que ella no puede hacer ejercicios. Tiene 84. Y vamos para allá.
E: ¿Y usted cuantos tiene?
F: Tengo 72, 75.
E: ¿Y siempre ha vivido aquí en Morelia?
F: Yo vivía en el rancho. En el rancho teníamos parcelas?. Y teníamos tierra. Y sangrábamos, y nos echábamos, y a mi me gustó mucho el trabajo del service. Para lavar me ponían montones de pantalones y yo me las ponía todas. Para lavarse, plancharse, cocinarse, fregar, hacer tamales, hacer tortillas, hacer gorditas. Y por eso. Ya en los años te tienen que salir también. Dicen que primera te sale en la cara. Por eso el doctor dice que estoy mal.
E: ¿Y resulta que es difícil cuidar a su hermano con respecto a la diabetes?
F: Yo no [INAUDIBLE] Le doy su fruta y comer a sus horas, hace la comida. Caldo de pollo, sopa de arroz, lentejas, [INAUDIBLE] Y fruta de la que yo pueda. Y porque no tengo amigos ni amigas. [INAUDIBLE] Arroz, avena, pues buena comida[INAUDIBLE] Pues las lentejas

tenemos muchos. Hasta[INAUDIBLE] los como. Cuando no tengo ni para tortillas. Como un plato de lentejas y estoy bien. No me siento mal.
E: ¿Y cuanto de menudo tienen que venir aquí al centro de salud?
A: A ella ahora le están dando insulina. Y pues, tenemos que revenir, cuando acabe la insulina. Y vamos viniendo cada vez porque nos están dando insulina. Pero ahora como no esta el doctor que la estaba viendo es….a poco ha quedado malo. Porque no todos son bueno, no todos son axial agrupados a la gente….Por eso. Y eso no los. Ayuda mas bien a uno, a veces …. Y dicen que esta bien, y les trata de otra cosa, nos ayuda. Yo tengo que ir a trabajar. Tengo mi jefe. Tengo mis quehaceres.
E: Como todo el mundo.
A: Como todo el mundo
E: ¿Y sí en su familia, su mama o su papa tenia la diabetes o no?
[interrupción]
E: ¿En su familia, alguno de sus parientes tiene la diabetes?
A: No. Nadie, nadie, nadie. Ni mi padre, ni mi madre, ni mis abuelitas, ni mis abuelitos. Nadie, nadie. Pero como mas antes. …Y ahora si. Y por eso están saliendo todos. Yo me hice el mamografía, para el cáncer.
E: ¿Pero de la diabetes, no?
A: No.
E: ¿Porque cree que se le ocurrió la diabetes a su hermana, entonces?
A: Este, cuando yo me casé….quedamos horas, y mi marido murió, y me dijo que vienes a con mi marido. Y peleaban y peleaban conmigo. Y como yo era la dueña de todo lo que era lo mió y entonces querían vender lo mió. Y los hijos…Y me botaron las llaves abrieron las puertas, se metieron primero que ella. Y echaron ella para afuera. Y luego yo llegué y les toque y pensaba que era un padre de ellos. Y fueron a la carrera para abrirme.[INADUIBLE]. Y los eché. Y les eché de volada. Entonces volaron por las puertas, y la muchacha andaba bien y la agarraron a pegadas como a perrito. Y ella se senito mal. Y desde ahí, tiene la diabetes. Por la culpa de esos animales.
E: ¿Y eso hace nueve?
A: Nueve años. Y por eso tiene diabetes. No es de enfermedad, es como de nervios. Es como de nervios su diabetes que ella tiene. Por eso ella anda ni feliz, ni infeliz. Por que ella, como duerme, como todo los medicinas que le den. [INAUDIBLE]. Estoy muriendo de esto, estoy muriendo de esto. Nada. Ella es [INAUDIBLE]. Con medicina o sin medicina. Porque la diabetes que ella tiene no es de enfermedad. Es una contraridad que ella tiene en su cuerpo. Por que eso, de susto y por coraje y como [INAUDIBLE]. [INAUDIBLE SENTENCES]. Y ella se enojo conmigo. Y vivía conmigo y con mi marido. Y mi marido ha sido [INAUDIBLE]. Porque yo me enferme del estomago. Y necesitaba un ayudo del trabajo. [INAUDIBLE]. Entonces mi marido me dijo esto que, vamos a mandarte tu y tu hermana [INAUDIBLE].

Rest of the interview is inaudible.

Interview with Sergio Flores Mendoza (P7)

E: Primero, me puedes decir tu nombre, y tu edad.

S: Soy Sergio Argan Flores Mendoza y tengo 27 años.
E: ¿Y qué nivel de educación tiene actualmente?
S: Soy chef. Estoy de licenciatura de gastronomía.
E: ¿Estás casado?
S: No.
E: ¿Tienes hijos?
S: No.
E: Bueno, pues la primera pregunta es ¿cuando te enteraste que tenías la diabetes, buscabas información?
S: Sí, buscaba mucha información acerca de la diabetes. Cómo iba a ser mi vida con diabetes. Empezaba a buscar mucha información, empaparme. Y de hecho como mi papa es medico, sus amigos, médicos que me atendieron me ayudaron con mucha información también.
E: ¿Y sobre todo donde buscabas?
S: En Internet. Pues que hay mucha información.
E: ¿Y qué encontraste que te encontraste?
S: Pues si, el que tiene acceso al Internet puede encontrar mucha información. Y como yo siempre he sido deportista entonteces, empecé ver mucho que alimentación, como va a ser, que ejercicios debo de contar. O si debo hacer mucho ejercicio o si debo hacer poco. Todo eso, empecé a buscar.
E: ¿Y que te causo la diabetes?
S: En cuanto a que?
E: En cuanto a…. Es que tampoco te quiero dar pistas. Que factores fueron? Que le dijeron cuando te enteraste.
S: En realidad como tengo diabetes juvenil, tipo I, me dijeron que probablemente fue alguna infección mal cuidada. Que fue [INAUDIBLE] En cuanto a la diabetes. Esos es fue es lo que me comentaron los médicos. Pues, en si, no se…
E: No, es tipo uno, así que es diferente. ¿Y adonde vas para tu tratamiento?
S: Ahorita, yo solo me trato por medio de insulina, y es lo único que…
E: ¿Y como es? ¿Todos los días?
S: Todos los días en las mañanas me inyecto una cierta cantidad de insulina.
E: ¿Y crees que era difícil aprender cuidarse?
S: No es difícil. Pero como no es una enfermedad que no te da lata, no….te sientes normal. Es muy difícil empezarse al descuido. A comer lo que sea, no se. Más bien como siempre he sido deportista me he cuidado la alimentación no fue difícil hacer ese cambio. Simplemente es no comer nada de azúcar y ya.
E: ¿Y cuanto tiempo llevas sabiendo?
S: Me diagnosticaron en noviembre del año pasado.
E: ¿Así que hace poco.
S: Sí, hace poco.
E: ¿Y has buscado información por otras organizaciones de salud aquí en la cuidad?
S: No.
E: ¿Y cuales son las peores cosas que puede pasar gente con esa enfermedad?
S: Las peores cosas. Perder extremidades, dañar otros órganos, como los riñones.
E: ¿Y para tí, cual aspecto de la diabetes es más importante? El ejercicio, la dieta, tu medicamento? O cómo lo ves de importancia?

S: Es igual de importancia. Para mi es igual. Debe de haber un equilibrio en todo. Por ejemplo yo empecé utilizando 32 unidades de insulina. Ahorita nada mas me aplico 24.
E: ¿Y eso, cómo has podido hacer?
S: Eso fue por la nutrición y por el deporte que empiece hacer. Entonces Simplemente uno empieza a conocer mas su cuerpo. A como te vas entiendo durante el día, y vas necesitando dosis.
E: Y háblame un poco de tu dieta.
S: Sí, puedo comer todo. Pero tengo restringido algunas verduras, por ejemplo papa. No puedo consumir. Pasta, todos los carbohidratos, o las harinas con consumo moderado. Poca grasa. En cuanta a carnes, también carnes muy magres con muy poca grasa. Nada de azúcar. De azúcar permitida por la nutrologa es la Splenda. Pero en si, todo lo de más puedo comer normal.
E: ¿Y a parte de eso, como te ha afectado la vida cotidiana? ¿Tienes tu rutina de medicamento, y aparte de eso?
S: Este, pues en realidad no me afecta mucho. Simplemente me levanto 7 u 8 de la mañana, lo primero que hago es inyectar. Después de mi inyección, tomo mi glucosa. Y es todo lo que hago durante el día. Puede ser me voy, trabajo un poco, a medio día hago mi deporte y en la tarde otra vez trabajo. Entonces en realidad no me afecta mucho.
E: ¿Qué es lo que te preocupa lo mas sobre la diabetes?
S: ¿Qué es lo que me preocupa? Pues en realidad no me preocupa. Como soy muy estricto en cuanto a lo que debo de hacer. No tengo ninguna preocupación.
E: ¿Y algo que te frustra sobre la diabetes?
S: Me frustro mucho porque, te digo siempre me habia cuidado, he hecho deporte y dije ¿por qué me paso a mí? ¿Por qué? Simplemente fue un momento así de pensar. ¿Si alguien que sí se esta cuidando le afecta con la diabetes, personas que no están cuidándose, que mas padecer?
E: ¿Y tus padres no son diabéticos?
S: No.
E: ¿Nadie en tu familia?
S: Nadie en mi familia.
E: Con respecto a la familia, ¿cómo te ayuda con está enfermedad? No se si es necesario.
S: Sí me ayudan mucho en cuanto a la alimentación. Ellos tratan de consumir también productos que yo puedo consumir. No sé si….pues mas que nada en cuanto a eso.
E: Es muy importante. ¿Pues, sí tu familia entiende la gravedad de la diabetes porque tu papa es medico. ¿Qué tipo de medico es?
S: El es medico, traumatólogo ortopedista. Pero como tiene médicos, tiene amigos médicos de otros áreas, el sabe.
E: ¿Y crees que los otros familiares entienden también?
S: ¿Familiares?
E: Pues, no sé si tienes hermanos, o hermanas.
S: Pues sí, sí entienden. Mi hermana, si me ve igual se me antoja un papa, me dice eh, y tal.
E: ¿Y crees que la gente de aquí, de Morelia, se entera de la gravedad de la diabetes? ¿De la importancia de esa enfermedad para la cuidad?
S: Creo que no. Por lo mismo porque no hay mucha información, en cuanto a esa enfermedad. Hasta ahorita que se esta bombardeando un poquito. Poquitito con más información. Pero la gente no se da el tiempo investigar exactamente a que los puede llevar si, se empieza a descuidar, la diabetes.

E: Bueno, hablando un poco sobre la información, tu decías que ahora ya si esta saliendo mas información. ¿Pero adonde has visto la mas información? ¿Así de vista en los medios, o si has visto información en un lugar en particular?
S: Radio. Esta manejando mucho la radio. Es que lo he escuchado más. Algunas cosillas de la diabetes, cuidándole, alimentación. Eso es donde he visto, o he escuchado más esta información.
E: ¿Y de qué va? ¿La detección? ¿El alimento?
S: Sí va mucho con la prevención. De que hagan sus estudios, por lo menos una vez al año. Y que se cuiden, porque es una enfermedad silenciosa. Entonces, se tiene que estarse checando.
E: ¿Y crees que aquí en la ciudad, para tí, para otros es mas una enfermedad del individuo o más de la sociedad? Según lo que tu has visto.
S: Se me hace que esta volviendo más de sociedad. Por lo mismo por ejemplo en las industrias de refrescos. Ahorita esta vendiendo refrescos con Splenda. Cosas así, así que esta volviendo más de sociedad. Antes, me imagino que antes era mas de uno. Uno veía como, o no comer de eso, o por el antojo o el animo, me lo como. Entonces ahorita ya por la sociedad ya no están dando chocolates sin azúcar, pan también, todo. Y que anteriormente no habia. Entonces ya se esta volviendo mas en cuanto a sociedad.
E: ¿Y sí, ahora, sí es mas fácil encontrar?
S: Sí, ahora sí, muy, muy fácil.
E: Una mas. ¿Hay algo específicamente que te gustaría ve que la ciudad haga sobre la diabetes?
S: Algo, que me surge ahorita en el momento es a lo mejor una campaña como hace de vacunas, en masiva, puede ser de detección de diabetes, no se. Pueden ir a diferentes comunidades y checar, checar, checar.
E: Bueno, pues ya es todo.

APPENDIX B

CONSENT FORMS

CONSENT FORM

I, _____, agree to take part in a research study titled "DIABETES IN MORELIA: A CASE STUDY ON THE CULTURAL FRAMING OF DIABETES IN MEXICO" which is being conducted by Everett L. Long, a graduate student from the Grady College of Journalism and Mass Communication at the University of Georgia, under the direction of Jeffrey Springston. My participation is voluntary; I can refuse to participate or stop taking part at any time without giving any reason, and without penalty or loss of benefit to which I am otherwise entitled. I can ask to have information related to me returned to me, removed from the research records, or destroyed.

The reason for this study is to know and understand my opinions regarding diabetes and how it is viewed in the city of Morelia.

I will not benefit directly from this research, which will expand the knowledge about how health organizations communicate about diabetes to diabetics.

If I volunteer to take part in this study, I will be asked to do the following things:

1. The time and place of interviews will be at the choosing of the researcher.
2. I will read and be asked to sign this informed consent form regarding my participation in the study.
3. I will have a conversation with Everett Long about life in Morelia with diabetes.
4. The conversation will last approximately one hour.
5. The conversation will be audiotaped and the researcher will take notes.
6. Follow-up conversations may be necessary. These would take place either in person, when the researcher returns to Georgia over the phone, or via email, depending on my preference.

No compensation or incentives will be provided to me for my participation.

No discomforts or stresses are expected. However, I might experience mild discomfort when asked questions regarding my medical status as a diabetic. I can withdraw from the study at any time or skip questions that make me uncomfortable.

No risks are expected.

The only person who will know that I am a research subject is the researcher. No individually-identifiable information about me, or provided by me during the research, will be shared with others

without my written permission. I will be assigned a pseudonym and this pseudonym will be used on all final reports and publications regarding this study. Audio tapes will be kept in a locked cabinet in the researcher's office and will be destroyed no later than one year after the interview takes place.

It is important to note in the case that follow-up interviews via e-mail are necessary, that Internet communications are insecure and there is a limit to the confidentiality that can be guaranteed due to the technology itself. However once the materials are received by the researcher, standard confidentiality procedures will be employed

The researcher will answer any further questions about the research, now or during the course of the project, and can be reached by telephone at: 001-704-657-5338. Researcher can also be reached by e-mail at: elong5@uga.edu. Dr. J. Springston can be reached at: 001-706-543-7833 or by email at: jspring@uga.edu.

My signature below indicates that the researcher has answered all of my questions to my satisfaction and that I consent to volunteer for this study. I have been given a copy of this form.

_____ _____ Everett L.
Long Signature Date

Telephone: 001-704-657-5338
Email: elong5@uga.edu

_____ _____

Name of Participant **Signature** **Date**

Please sign both copies, keep one and return one to the researcher.

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone 001-706-542-3199; E-Mail Address IRB@uga.edu

CONSENTIMIENTO PARA PARTICIPAR EN PROYECTO DE INVESTIGACION

Yo _____ acepto participar en el proyecto de investigación titulado "LA DIABETES EN MORELIA: UN CASO DE ESTUDIO DEL MARCO CULTURAL DE LA DIABETES EN MEXICO**"**, el cual es conducido por Everett Long, un estudiante de la Universidad de Georgia (College of Journalism and Mass Communication, Universidad de Georgia, EEUU., teléfono: 001-706-542-5680), bajo la direción de Jeffrey Springston. Entiendo que mi participación es completamente voluntaria; pudiendo retirar mi consentimiento en cualquier momento sin presentar ninguna razón y sin ninguna penalidad para mi o pérdida de beneficios a los que yo pueda ser acreedor. Puedo solicitar que toda información mía me sea entregada y no ser parte de los archivos de este estudio.

La razón del estudio es recabar mis opinions con respecto a la diabetes y cómo se lo entiende en la ciudad de Morelia.

No me voy a beneficiar directamente del estudio.. El estudio expandirá el conocimiento de cómo las organizaciones de salud comunican sobre la diabetes.

Entiendo que si voluntariamente participo de este estudio eso implicará lo siguiente:

1. El lugar y momento de la entrevista sera elegido por el investigador.
2. Yo leeré esta autorización antes de que el investigador solicite mi firma en dicho documento
3. Tendré una conversación con Everett Long acerca de la vida en Morelia y la diabetes.
4. La conversación tendrá una duración aproximada de una hora.
5. La conversación será audio grabada y el investigador tomará notas.
6. Es posible que se necesiten otras conversaciones cortas después de esta entrevista. Dichas conversaciones serían por teléfono o por correo electrónico, dependiendo de mi preferencia particular.

Por mi participación en el estudio no recibiré compensación monetaria o de ningun otro tipo.

No se anticipa que el estudio produzca estrés o incomodidad de ningun tipo. Puedo retirarme del estudio en cualquier momento, o no responder preguntas que me produzcan incomodidad.

No se anticipa que el estudio tenga riesgos de ningun tipo.

La única persona que sabrá de mi participación en este estudio es el investigador. Ninguna información sobre mi, o suministrada por mi será publicada o compartida con otros sin mi permiso escrito. Las cintas grabadas durante las entrevistas y las transcripciones que de ellas se hagan serán etiquetadas con pseudónimos. Estas cintas de grabación estarán en un gabinete bajo llave en la oficina del investigador y serán destruidas en un plazo no mayor de un año luego despues de la entrevista.

Es importante hacer notar que en el caso de que sea necesario hacer más entrevistas vía e-mail que la comunicación por Internet puede ser insegura y tiene limitaciones respecto a las garantías de confidencialidad dada la tecnología. Pero una vez que la investigadora tenga el material se utilizarán los estándares y mecanismos de confidencialidad más estrictos.

El investigadorr contestará cualquier pregunta o duda que usted tenga ahora o en el futuro acerca de este proyecto de investigación. El puede ser localizada por teléfono en Los Estados Unidos (**001-704-657-5338**), o via correo electrónico: **elong5@uga.edu.** Dr. J. Springston puede ser localizado al 001-706-543-7833 o via correo electronico: jspring@uga.edu

Entiendo que el firmar este documento se interpreta que estoy de acuerdo en participar en este estudio y entiendo que recibiré una copia de este formato para mi archivo personal.

Everett L. Long Ph: 001-704-657-5338 elong5@uga.edu	_____ Firma del Investigador	_____ Fecha
_____ Nombre del Participante	_____ Firma del Participante	_____ Fecha

Por favor firme las dos copias de esta forma, quédese con una copia y devuelva la otra al investigador

Preguntas adicionales u otros problemas en relación a sus derechos como participante de este programa pueden ser dirigidos The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411, USA, teléfono: 001-(706)-542–3199; Correo electrónico: IRB@uga.edu

APPENDIX C

THE INTERVIEW GUIDES

Demographic Information:

1. What is your age?
2. What is your gender?
3. What do you do for work?
4. What is the highest grade in school that you completed?
5. Were you born in Morelia?
6. How long have you lived in Morelia?
7. Do you have children?
8. How many people are in your household?

Access to information:

1. Do you have a television?
2. Do you watch the local news media on television?
3. Do you have a radio?
4. What do you listen to the local news media on the radio?
5. Do you have a home computer?
6. Do you have access to the internet?
7. Do you have a home telephone?
8. Do you have a mobile phone?

Interview guide for people with diabetes and family Members:

People with Diabetics

Health information

How did you find out that you had diabetes?
What did you know about diabetes before you were diagnosed?
When you first found out that you had diabetes did you look for more information about it?
If so, where did you look? Tv, radio, internet?
Did a friend or family member assist you with an internet search on diabetes?
Did you ask your doctor about diabetes?
Did/Do you ask your family about diabetes?
Did/do you ask your friends about diabetes?
Did/do you read any books about diabetes?
Did/do you use the internet to find out more information about diabetes?

Did/do you go to any health organizations to get more information about diabetes? Which?
Do you remember finding information that was helpful? Did you find anything about diabetes that surprised you?
Where do you feel you got the most information about diabetes?
What, if any information do you feel you could have used more of when you searched?
Where else have you seen information about diabetes in Morelia?
Do you get information about diabetes from your local news paper? Which?

Care

1. Where do you go to get treated for diabetes?
2. How often do you go?
3. When you go, what is the routine?
4. Are you appointments on a regular schedule, such as once every month or every six months, or do you only see a doctor or nurse when you feel sick?
5. How easy is it to get a doctor's appointment if you need a visit outside of your routine check?
6. Do you feel you should have more visits with the doctor? Fewer?
7. What would you like to see done in Morelia with respect to people who have diabetes?
8. How easy or difficult was it to learn to take care of your diabetes?
9. Are there aspects of self-care that you feel you should change?

Health Beliefs

What causes diabetes?
What are the worst things that can happen to people with this disease?
What factors do you think contribute most to being/becoming diabetic? Family history? The foods one eats? Being overweight?
How important are the following for people with diabetes: healthy diet, exercise, proper medications?
How does being diabetic affect your daily life?
Besides medications, what do you feel are things you can take/use to help with your diabetes?
What's worrisome about diabetes?
What is frustrating about diabetes?
What do you fear most about diabetes?

Social Support

7. How does your family help you in your being diabetic? Take you to the doctor? Prepare healthy meals? Helps you take your medicine?
8. Do you feel that your family understands what it means to be diabetic?
9. How does diabetes affect your family/social life?
10. Do you feel that people in Morelia are aware of diabetes?

11. How do you think your friends and family view diabetes?

Other
1. Where you aware that this year in March Morelia hosted the 7th annual International Conference on Diabetes Mellitus?

Family Members

Health Information

1. What did you know about diabetes before your family member was diagnosed?
2. When you first found out that your family member had diabetes, did you look for more information about it?
3. If so, where did you look? Tv, radio, internet?
4. Did you ask your doctor about diabetes?
5. Did/Do you ask your family about diabetes?
6. Did/do you ask your friends about diabetes?
7. Did/do you read any books about diabetes?
8. Did/do you use the internet to find out more information about diabetes?
9. Did/do you go to any health organizations to get more information about diabetes? Which?
10. Do you remember finding information that was helpful? Did you find anything about diabetes that surprised you?
11. Where do you feel you got the most information about diabetes?
12. What, if any information do you feel you could have used more of when you searched?
13. Where else have you seen information about diabetes in Morelia?
14. Do you get information about diabetes from your local newspaper? Which?

Care

1. Do you feel that there are sufficient organizations that deal with diabetes in Morelia?
2. Do you feel that your family member has sufficient information from local sources to properly deal with his/her diabetes?
3. What, do you think could be different about the health care organizations in Morelia that would help your family member better deal with their diabetes?
4. Do you think your family member has proper access to information about diabetes?
5. Do you think your family member has proper access to treatment for his/her diabetes?
6. What would you like to see done in Morelia with respect to people who have diabetes?

Health Belief
1. What causes diabetes?
2. What does having diabetes mean for someone?
3. What are the worst things that can happen to people with this disease?
4. What factors do you think contribute most to being/becoming diabetic? Family history? The foods one eats? Being overweight?
5. How important are the following for people with diabetes: healthy diet, exercise, proper

medications?
6. How does being diabetic affect your daily life?
7. Besides medications, what do you feel are things you can take/use to help with your diabetes?
8. What's worrisome about diabetes?
9. What is frustrating about diabetes?
10. What do you fear most about diabetes?

Social Support

1. How do your help your family member with his/her diabetes? Taking them to doctor's visits? Preparing healthy meals? Helping with medications?
2. What do you do specifically to help your family member with his/her diabetes?
3. How do you feel your family member being diabetic affects you and your family?
4. Do you feel that life is difficult for someone with diabetes?

Interview guide for health professionals:

Health Information

1. What health information does your organization provide about diabetes?
2. What channels do you use most? (small media, tv, internet, newspapers)
3. Do you feel that there is sufficient information about diabetes to be found in Morelia?
4. Where in Morelia do you feel that the most/best information about diabetes can be found?
5. Do you feel that most diabetic Morelianos actively search for information about diabetes? Why?/Why not?
6. Where/with whom do you feel they search most?
7. Where do most people get their information about diabetes?
8. What do you feel is the best way to inform Morelianos about diabetes?
9. What information does your organization prioritize as important information to disseminate to diabetic Morelianos and their families?
10. How do you feel the news media handles diabetes, if at all?
11. How do you as a health professional stay informed on diabetes?
12. Are there any debates about the disease that are particularly pervasive in Morelia?

Care

1. What do you emphasize when you are talking to a diabetic patient?
2. Do you feel that there are sufficient organizations that deal with diabetes in Morelia?
3. What, do you think could be different about the health care organizations in Morelia that would help your diabetic patients better manage their diabetes?
4. What would you like to see health organizations do more of in Morelia with respect to people who are diabetic?
5. Do you feel that people with diabetes have sufficient access to health organizations?
6. Which do you think are the best health organizations in Morelia that deal with diabetes?

7. What aspects of diabetes care does your organization emphasize with respect to diabetes?
8. What aspects of diabetes does your organization feel are most important in keeping diabetics most informed on how to care for themselves?
9. What is the best way to provide this information?
10. Besides medications what are some other ways that Morelianos manage their diabetes? Religious/herbal remedies etc?

Social views of diabetes/Health Beliefs

1. How do Morelianos who suffer from diabetes feel about the disease in general?
2. What aspects of diabetes management do you believe stands out to Morelianos who suffer from diabetes? Self-care, such as exercise and diet? Serious complications, such as blindness?
3. What do your patients believe causes diabetes?
4. Are Morelianos with diabetes stigmatized or discriminated against in anyway?
5. Do your patients feel that they are capable of successfully controlling their diabetes?
6. Are there any specific beliefs that people hold about diabetes?

Social Support

1. From what you see through your organization are family members supportive of diabetics?
2. In what ways do you see this support or lack of support?
3. What other support do you feel is available for diabetics?

Interview guides for journalists:

Health Information:

1. As a journalist how important do you feel it is to report on diabetes as a health issue in Morelia?
2. What aspects of the disease do you feel are most important to highlight when reporting on diabetes?
3. Are your editors interested in the subject of diabetes? What types of stories are they most interested in? New medical developments, profiles of patients? Prevention? Treatment?
4. How important do you feel it is to report on preventative measures?
5. How important do you feel it is to report on diagnosis?
6. How important do you feel it is to report on proper treatment/maintenance of diabetes?
7. What do you think is the best outlet to for Morelianos to find information on diabetes?
8. Where do you think most Morelianos go to get information on diabetes?
9. Do you think there is sufficient coverage/information available to Morelianos about diabetes?
10. What could be improved?

Social Views of diabetes:

1. How do Morelianos, those with or without diabetes, feel about the disease in general?
2. What aspect of diabetes management do you believe stands out to Morelianos? Medicine? Getting diagnosed? Diet?
3. Are Morelianos with diabetes stigmatized or discriminated against in any way?
4. Are there any specific beliefs that people hold about diabetes?
5. How did the fact that Morelia held the 7th International Conference on diabetes affect the coverage of diabetes in Morelia?
6. Did the everyday Morelo suffering from diabetes feel the impact of an event this large surrounding the issue of diabetes?
7. Did any other significant news media arise from the conference?

APPENDIX D

ANALYZED CONTENT

Public health facts

PERSPECTIVE

Disease rates/incidence

J2: This is one of the principal diseases, not only in Michoacán, but also in all of Mexico. We have high obesity indexes, which also comes as consequences of diabetes.

J3: There [IMMS] they have a list of 56 thousand diabetics in Michoacán. That's just in the social security. One would have to add the ones from the Ministry of Health and one would have to add the ones that go to private hospitals. Although arterial hipertension has already surpassed diabetes. At least at IMMS.

H3: And the truth is that I don't doubt that we in Michoacán hold first place in obesity.

H3: Here in Michoacán there are about one hundred thousand diabetics. But if I put together the Micoacanos that there are in the U.S., there are more there. There are about 7.5 million [total Michoacanos in the U.S.], here there are about 4 total.

H3: I can tell you then that in general that according to the predictions for the year 2025 we will have 700,650,000 diabetics.

H4: How do you combat obesity in a country that consumes the most soft drinks in the world?—Mexico. Mexico is the largest consumer of soft drinks in the world.

H5 It [diabetes] is linked to other important problems in the state like renal insufficiency. We have a huge problem in the state with renal insufficiency.

Disparities

J2: And it [diabetes] is also a genetic problem for Hispanics.

J3: Here in Michoacán we have a severe obesity problem among children. I think that the secretary of health commented to me that we occupy fourth place in the number of children with diabetes, at the national level. Fourth place nationally.

H3: I see here in Michoacán…as we are Latino Americans we have a higher proclivity to diabetes.

H3: Because of the way we eat, because of our idiosyncrasies, and because we have a high proclivity. And in the U.S the numbers have gone up. There were 20 million [cases] several years ago. Now I believe there are more. And the Latino population, and the black population, has more. Us, we have more of a proclivity to diabetes. But they [those of European decent] have a higher proclivity to other diseases.

H4: Because you know, here in Mexico we are in first place in childhood obesity in the world. And for adults we are in second place. Only the United States beat us.

http://www.nationmaster.com/graph/hea_obe-health-obesity

Risk Factors

J3: Becoming obese equals diabetes, period.

J3: Overall because I know that if some of my relatives have diabetes, surely I'm going to have it. And you know it is hereditary. The hereditary factor is the principal [reason] that diabetes appears. Yes, I think that people are interested, but when they have an example of someone who has been affected and their kidneys don't work, etc.

H1: Some people think yes, by having the genes there is risk, and few take any action. They take their glucose levels periodically, watch their weight. But the majority don't pay attention to this, and they develop diabetes.

H2: And they don't imagine what we're going to talk about until we arrive and say, "we're going to do something practical". "We are going to do a workshop". Then we begin by saying, "I have my scale here, my tape measure, I'm going to determine body mass index. We are going to see how many of us are not at a healthy weight. Then people began to become conscious, because here I have the principal, the teacher who invited me. The parents of the families are there. But when I involve them, there is a moment that makes an impression, and they began to say, "well, we didn't know this," "I think that this is healthy."

H3: The people of Michoacán, the only part of the pig that they don't eat is the hooves. We eat the intestines and this is bad for you, to eat the intestines, eat the fat of the pig. But we don't want to eat a better cut of pork, lean meat, without fat. Nor eat white meat: chicken, fish, turkey, beef, and if you don't want this, well eat cottage cheese.

H4: The biggest problem of obesity in Michoacán, he [the director] can describe it to you, is centered in the indigenous communities. Where the food is corn based—posole, tortilla, tamales, tacos, tostadas, all of this is made of corn.

P1
E: What caused your diabetes?
C: Well, probably obesity. Surely obesity. Well, there are many factors. My obesity, you know I got married at 15, I had a baby, and I got fat. From that point on it started. But if one doesn't know anything…What does one do when they don't know that [lifestyle] is what causes this [diabetes]? And my family, my family, including my mother has all ended up with diabetes.

P1
INT: So did you know about diabetes before? Did you know that you were susceptible?
C: Not until I started to come here. Yes, a little before, I began to see my mother get sick. And the ignorance. Sometimes there are so many errors, we committed so many errors out of ignorance
P2:
INT: So, what causes diabetes?
A: Bad food above all. And heredity. My parents were diabetics, so I inherited it.

P2: But before if someone tells you, “don’t get fat because you’re going to get diabetes”, right then you don’t feel it.

P4
INT: And what caused your diabetes?
Ana (patient): I weighed 110 kilos [242lbs].
Dr. Marquez: Obesity.
A: I say that’s what it was.
M: Yes, that was it.
A: I weighed 110 kilos.
M: And are you mother and father diabetic?
A: No.
M: No one else? Diabetic siblings?
A: No. I only have a sister, and she doesn’t have it.

P7:
INT: And what caused your diabetes?
S: Well, really since I have type 1 diabetes, they told me that it was probably some infection that wasn’t cared for properly.

Prevention

J1: And I think that in Michoacán the Secretary of health has done enough diffusion about what diabetes mellitus is. And the consequences, especially the social security (IMMS)—those that are hypertensive and what we can suffer from with the disease. I think that they have done works about prevention.

J1: But I think that the most important thing is to know the disease. What brings it on, how to prevent it. I'm sure that the most important is measures of prevention.

J1: I think that designing programs, political, publics with constant diffusion through informative media. In schools, for example. I think there lacks basic health education, let's say in primary and secondary school. Health education. And the kids from primary school should be taking about this, no? Because it's a public health problem. It's very grave in Michoacán. And the parents don't do it. So this corresponds also to the Ministry of Education. These themes should be included in text books. Yes, they do it, but it's in a very superficial way. And so that when you're an adult you'll be more conscientious. Because we don't exercise or we do very little. We have to begin to do something in the schools, and also stop permitting junk food. Precisely for the same reason. And we have to inform them.

J2: Then to diffuse themes about this disease that one can prevent, that one can retard, well it's very important that people be on this side, right?

J2: …it's recently that there is more service journalism. What is precisely what that is, not only "There are this many diabetics". But also, where to go, how do you prevent it, what can one do. To give the people the elements so that they know what to do or how to prevent it.

J2: Well, it's all in prevention. In the little ones, in children if we begin to teach them that natural things are better, that one shouldn't eat so much sugar.

J3: How is it possible that a disease like diabetes, that in spite of it not having a cure, we all know that, but if it is a disease that can be cured with basic things that if from childhood we educated to do exercise, sports, to eat well, to eat at the proper times…what else have the doctors said? Not to eat junk food, avoid obesity.

J3: Yes, the statistics, like in all of journalism. But specifically in the articles of health. It's important that they here that there is a certain amount of cases of diabetes, or that the number of diabetes increase so many people. But in spite of the fact that the first few paragraphs reports the amount of cases this year, in the following paragraphs of the article I put it in context and always try to reiterate that diet, exercise, not eating junk food, even though I seem like a broken record. They get mad that I write that. Or sometimes they shorten the article, but I always try to put it in some context where I say that this, this, and this are important.

J3: This is a problem that we have to eradicate through education, not only through doctor participation.

J3: Here in Michoacán there is a large part of people who exist that need a kidney transplant, and the majority need it precisely because they were diabetics. So, when we could have prevented someone's need for a kidney, or being on dialysis or hemodialysis…Yes, here there is a culture that you give your family member a kidney. But this is also a conseqence of diabetes. But why it is necessary for me to live with only one kidney when the person who I donate it to could've prevented getting diabetes in the first place? If from children he or she ate well, did some exercise or such basic things.

H1: Again, as there isn't health education, people don't achieve prevention. Lets say, five percent of the people at CEYAMED achieve prevention, and the other ninety-five percent arrive because they already have complications. Unfortunately.

H1: Well, medicine should be to prevent, in all cases. Unfortunately that's not what we do.

H2: In spite of the fact the center is a center of attention [for diabetes], and with the end in mind of prevention, the last five years we have more dedicated to the diagnosis aspects of diabetes. Although we give talks about what diabetes is, preventative measures, and things around that. But particularly, people arrive here already with some symptom.

H2: It has been very hard to communicate with the state health authorities. Because it isn't necessarily the experts who attend, but their associates, and sadly the information isn't diffused, and I don't know if it's a good diffusion of prevention [information].

H2: Because perhaps tomorrow he or she isn't the only person in the family that has it [diabetes], one. Two: because if they don't take care of themselves it's possible that there will be complications. And now who's going to take care of that person? Three: and if there is no one to take care of that person, how is the economic situation. Four: in a given moment when we already have a patent and we have to mutilate them because they were not under control, he or she has diabetic foot, or what have you, who is going to be the economic support of the family? Where is the family going to go? So the idea of our talks with the family is to get ahead of that. To say, the situation of the family right now is this; in 5 years it could be this, in ten years it could be this. We see little kids who become adolescents, adolescents who leave home, and they leave older people. If one of the two has diabetes how are they going to make it? What are we gong to do? The disease is chronic and it costs. And we all would have to make an effort to identify a chronic disease to live with it.

H2: If we don't begin to tell them what is happening, this is what's going on with the pancreas, or not only is it going on with the pancreas, but it harms other organs, etc. Perhaps, we begin by saying, starting to care for yourself you have to follow the medical indications, that you have to continue living, that you can't just hide under the covers and say, "I have diabetes and I don't want to go out."

H2: Well, I think in the educational programs, where one supposes that there are in the schools.

H3: Beans no, they are legumes. Legumes like beans and lentils in moderation. So, if you don't have meat, eat beans. But please vegetables during the day, green leafy ones. Spinach. What others do you know?

H3: And then you will know how to end this diet. I have this guide. Copy this, and make it smaller, then have them laminate it for you.

H3: You have to eat two that are this size. Take your coffee or your oatmeal. And eat two tortillas, this size. Or if not you eat one normal size wheat roll. You fry two egg whites and you eat that with the tortillas. And you can have some orange juice.

H3: And we review well with them how to train for exercise. And exercise has a meaning. During exercise muscles burn and absorb things without the necessity of insulin. So the patient saves insulin. And additionally it diminishes the resistance to insulin.

H3: We give them education so that they don't get to the point of complications.

H4: What happens is that you see more people, diabetics, preventing a fatal ending. Fewer are the diabetics that are controlling their diabetes through diet and exercise.

H4: But the best would be prevention. And one gives prevention at a young age, or as young adults. How? Physical activation and a healthy diet. Nothing else. Because I feel personally that the government of the republic should work in two area a lot stronger, one, in the educational sector. From children…And two, a more coinciding between the mediums of communication, in a strong way. Investing in the media and communications for prevention action. With respect to prevention, I assure you that the institutions are…very diminished. Because those who have rights to the services crowd the consults and crowd the hospitals. And you have very little time for a culture of prevention. So those are the two fundamental pillars. Overall, education.

H5: In October we celebrate Senior Citizen Week. That is a week where we celebrate federal health. Where, of course, the diagnosing diabetes is intensified.

H5: In all of our health fairs, even if it's not about diabetes, there is a detection of diabetes, and weight and height. This is one of the components we put in all health fairs, even if it's about something else. And it's one way to bring knowledge about this disease closer to the people.

P1: Because Mondays and Wednesdays I'm at the "5th of February" Group, which is the health center group. Tuesdays, Thursdays, and Fridays I'm at Health Child. And back at the health center Tuesdays, Thursdays and Saturdays. Tuesdays and Thursdays I'm here from 10-11, then I leave really quickly. And that's how I go on. What do you think? If I go home I do my chores. But I've felt really good.

P2 INT: Clearly. And what information did you get in the end? What important things do you remember?

A: Careful eating. Eating and the medicines, that we should use more ore less. Yes, that was the most important.

P2
INT: And for you, what is the most important about diabetes: exercise, the medicine?
A: Well, right now exercise is the most important.
INT: And where do you go now for exercise?
A: The exercise we do now is very light. I just do walks. Just walking…
INT: Everyday?
A: Yes, I try to do it everyday.

P3: Few pay attention to that. Few people have the knowledge. Many times they say, and this is not knowing, many times they say, "I have to loose weight, I already quit bread." But then eat a lot of meat, a lot of junk and not getting any vegetables. Then if someone tells you to lose weight, if they don't give you the knowledge, you don't lose weight. This is what has happened to us.

P2: Yes, what happens is, how do I say, while you aren't sick it isn't important to you. When you are sick that is when you want to prevent and when you want to exercise and stop eating.

P3: And many people don't listen. We have children that don't listen. They don't listen. We are watching and look child, prevent this so that the same thing doesn't happen. Then they turn around and it's happened, the same. Then there is a moment in which they listen and when we realize that we are already inside the disease.

P2 INT: Well, there should be more focus on prevention.
A: Yes, because in many places, for example on the tv, they give it to you superficially. If you want to take it, you take it. But if you aren't sick, you don't take it. You take it when you are already sick. When you have to start paying attention so that you don't have complications ahead. But before, if someone tells you not to get fat because you're going to get diabetes, you don't feel it. And you've already have now to care for yourself. Then when things change, we stop.

P7: By nutrition and sport that I started doing. Then you simply begin to know you body more. How you are during the day and what dosage [of insulin] you need.

P7:
INT: What is it that worries you the most about diabetes?
S: What worries me the most? Well, the reality is that I don't worry, since I'm very strict about what I need to do. I don't worry.

P7:
INT: Well, talking a little about information, you said that now more information has come out. But where have you seen the most information?

S: The Radio. There is a lot now on the radio. That's where I have heard the most. Some things about diabetes, taking care of oneself, food. That is where I have seen or heard more of this information.
INT: And what is it about? Detection? Food?
S: Yeah, it's a lot about prevention. That people should get a test, at least once a year.

MONETARY COSTS

J2: And also it's a heavy cost for the government, treating all of these people.

J2: Well that is another situation. Because in Mexico the social security isn't free for everyone. I think that this is another reason that people don't treat themselves. It's expensive.

J3: The subject of diabetes is extremely important because according to the Ministry of health, that continuously reports that it is the disease that represents the highest cost for public health.

J3: The Mexican Institute of Social Security is the institution that has the largest quantity of patients, I think that 80% or a little less than 80% of the budget goes to taking care of chronic degenerative diseases like diabetes. Diabetes heads up along with arterial hypertension. That speaks to us about a true public health problem.

J3: Once, the health journalists won the front page because the director was very interested in what had occurred to me to ask the IMMS delegate. I asked him, "Dr. how much the this institution spend on treating chronic degenerative illnesses?" And he told me that, "80% of our budget." And I asked him how was that possible? Is it true? He replied that it was, 80%. And that's how we won the front page: IMMS SPENDS 80% OF IT'S BUDGET ON CHRONIC DENGERATIVE DISEASES."

J3: And you know what influences a lot? Poverty. Because here in the interior the state, Michoacan is one of the poorest states in the country. There is urban poverty here in Morelia. Yes, there is. One doesn't always take it into account but there is. Almost always the authorities pay more attention to the extreme poverty, there's more of that in the peripheral zones of the state.

H1: Many of this corresponds to the state. Then, the government, sometimes, begins with their radio spots about diabetes prevention, the complications, and the same for obesity. And in this way they can reach out a little more to the people. Here we were doing it for a while, but it's expensive. Definitely, the one with the money is the government.

H2: When they feel bad. And not only when they feel bad, when they have economic resources. One of the biggest limitations for us is that. If you say to a patient that you have to come every month, and we make concessions to give packages, where we write you in for twelve sessions and we charge for tend. But in the end the person doesn't go. With the statement, "I couldn't come doctor because I couldn't pay for the consult."

H3: And we give them food so that they can utilize their nutrients. One thing is food. The food that they can get, that is in reach of the people and then we can control something.

H4: Because a large portion of the earnings of these institutions goes to attention to chronic degenerative diseases derived from obesity.

H4: Just this million of kilos represents to the country a savings of 19 hundred thousand pesos.

H4: And on the other hand you see more diabetics hospitalized there. You see more diabetics occupying beds in a hospital that other people need. But you can't kick them out. They are disobedient, but they have paid into their insurance, etc.

H5: I think that something that also influences a lot to a large part of the population here is economic resources. And access to medicine is hard. And when the health institutions are lacking people have to buy it. And when they have to buy them, if they have to buy them, many times they don't have money.

H5: I can tell you that one year ago one of the difficulties that the Ministry of Health had was having was economic resources to buy medicines. So, even if you give them the best medical knowledge that you have, if you don't have medicine and they can't get it, well it doesn't go anywhere. And it's not the fault of the ministry, nor the fault of the people, but instead the consequences of this country.

P2/P3:
[Wife to husband]
C: Well at least I bring him, because he didn't want to, right?
A: Well, I don't have time.
C: Sometimes, we don't have money.
A: My work is not normally here in Morelia, but instead in the areas around it. I bring people out and I have to go out with them. But now I had to come for the consult, and tomorrow I go back.
C: That's why sometimes he doesn't

CONSEQUENCES

Mortality rates

J1: I have an uncle in New Italy that died in November from the consequences of diabetes. He couldn't walk any more, she has a useless foot, etc. a toe as well, I think. I don't know how wounded he was. And since he lived alone, he didn't have a wife, nor children. And he was a country man, so he lived in a desolate area

J3: Here in Mexico the main cause of death in the country is heart attacks, what the doctors call coronary disease. Well this cause, the main cause of death, is attributed to complication of diabetes. Then that tells us that in Mexico diabetes could be the main cause of death. Because this quantity of heart attacks are products of diabetes. Because of that many doctors say that it is really diabetes that is killing people.

Mortality disparities

Consequences of improper care

J3: But additionally, people don't measure the gravity of the public health problem of diabetes. Why? Because maybe they say, ah this patient has kidney illness. Something in his or her kidneys is not functioning. That's a lie. It's becasuse the patient is sick because they are suffering from renal insufficiency as a result of diabetes.

H5: Well, we'll say that from the public health point of view of the programs, etc., I think that in the Ministry of health, there is a consciousness that it is a serious problem. From the epidemiological point of view, you know? Because the percentage of people that it [diabetes] affects, because of the consequences that it has on the general population, on the economy, on people and the country. Because this is one of the roads to catastrophic costs in becoming poor. In the health organizations themselves, I suppose…I believe that it is the main cause of non-traumatic amputations. It's diabetes. And yes, it's relatively frequent in the hospital, of course. I believe that 60% of renal insufficiency is attributed to diabetes. In other words, it's a public health problem.

P2: What could happen? Well, I could get gravely sick. Less health for me. That is why we must begin to take care of ourselves more.

P2/P3:
INT: And what worries you the most about the disease?
A: Well, that I won't take care of myself and that it will advance faster and more terribly.
C: And that we can't control it. For example, right now we don't understand it well, right? We change medicine and we don't understand why

P7:
INT: And what are the worst things that can happen to people with this disease?
S: The worst things. You can lose extremities, do damage to other organs, like your kidneys.

P7:
INT: And what frustrates you about it?
S: I get frustrated a lot because like I told you, I've always taken care of myself. I've done exercise. And I say "why did this happen to me? Why me?" It was just simply a moment of thinking like that. But, if diabetes still affects someone who is taking care of themselves, what do those who aren't taking care of themselves suffering?

Consequences of treatment

H2: There are those who come to our registration table to say, "I want to see if I can take my glycemic index before, because I the insulin shot makes me panic". And you see that and you think, well if you had tried the insulin, I assure you that you would've had a better physical condition and a better life.

H3: But here we give them a healthy eating habits. That is to say a balanced diet. We have our five fundamental nutrients, sugar, or carbohydrates, protein, fats, minerals, and vitamins. And we add a bit of fiber. Then, they eat the appropriate amount in relation to their weight, or their body mass index. Then they begin exercise and begin to control diabetes.

H3: What happens is that some are capable with the glycemic control package, to control the cholesterol and the other factors. And many respond well. We are operating at about 65% efficiency.

P1: Because every Monday and Wednesday I am at the "February 5th" group, that is the group at the health center. Module 8, of the health center. Tuesdays, Thursdays, and Fridays at the Child of health. And here at the health center I come Tuesdays, Thursdays, and Saturdays. And that's how I get on. What do you think? I get home and go on with my chores. But I've felt very good.

SOCIO-CULTURAL SCHEMA
Social-Self

J1: And close to there lives my aunt, another aunt, about 50 years old, that works. She's a single mother, a widow. And she knows she has the disease.

J2: Yes, it is stigmatized. Because diabetes is bad and it's a disease that kills you. And not always. Well when you have diabetes at its maximum, yes. But before no, befoe that you can treat it.

J2: I think that right now you see it more as the individual. Yes, I think that it is beginning to be a bit more in the social conscience that it is a disease of society. More because what I said about obesity. It's becoming something that is part of society. But right now it's "HE has diabetes."

J3: I don't think so. I think that diabetics suffer the least discrimination. I think that since it is a chronic degenerative disease that doesn't reflect itself in a physical aspect, at least until you have renal insufficiency, there you can see it some. Many people live with diabetes. But since that are controlling it with medicine no one realizes that they have diabetes. Then there are other specialists that say that diabetes causes depression. They say, "I'm diabetic, am I going to die? There is no cure, I'm going to die in 10 years." But here in Michoacán there is less discrimination than people with HIV.

H1: No, no, no, there isn't discrimination against patients with diabetes. Many hide their disease. Because, well, that's part of the denial. And some stay that way all of their lives, in denial. But the majority accept their diabetes. And if they have good control of their diet, exercise and medication, as they say, it doesn't even seem like they have diabetes. But it depends on the level of acceptance of the disease.

H1: Today diabetes is not considered an individual problem, but instead a public health problem.

H1: If anything is changing it is that. I have been managing diabetes since 1976, at the National hospital of Mexico, and later I came here. At that time much of the responsibility was basically put on the patient. Now, all of that is changing. The responsibility is shared. And one has to look for family support. You can't just leave the patient alone. And it's very common, for example, that everyone else is eating unhealthy food, and the patient has his or her vegetables, no, no. All of that has to change. The same eating habits that the patient takes on and the exercise, the family has to do as well. And also, the other thing is that we look for is that the family doesn't become the police, you know? Because later on they will say, "don't eat this." No, no, no. The patient has his or her responsibility. And they [family] are going to help prepare the healthy meal, and do the best they can with their diabetes. But, we can't let them become the police. Because that is far from helping, and so not to generate conflict.

H2: And if you are a Mexican woman, at a certain age, because of menopause or what have you, because of psychological problems in the couple's relationship that can enter because of menopause, they stop taking care of their physical presence and tend to get fat. When you ask them why are you fat, they say, "because it's natural. I've already had my kids and they are

older. There is no one who comes to see me, so of what importance is it? Since I don't have many things to do, given that my children are grown, I dedicate myself to eating." There we can see that there is an ignorance of what health is. But, integral health.

H2: There are some who come to talk to you, to tell you a lot of things that aren't about the disease. "All of this is happening to me outside of my family, and I don't know how to resolve it". And so we organize talks to talk with the family, especially heredity and treatment of the patient, acceptance by the family, and to avoid the signaling that in the family there is a person with diabetes and that we all must revolve around him. So our talks are sort of the same thing that happens with alcoholics. We are not going to revolve around him.

H2: The success we have is through a decalogue that we have. It begins by saying, "my person," and ends with the family in general. And end by saying that with respect for others as well as myself. And when one begins to deny it, with which of these points are you not complying? Because here it says that I am making myself responsible, so decide and do it. Because the way or the belief that we are offering you is a function of your family, a function of others that have the same suffering and a function of society.

H3: We could have the medal of victory given by the Joslin clinic. But we can't afford it, and so we look for other ways to give them a prize and recognize their efforts. And some are very smart, very capable. Some. And they follow their exercise to the letter. And they do it daily, as they should

H5: another thing that we do regularly is every November 14, I think that is world diabetes day, the self-help group celebrates with an event in which we invite people from other regions and they help. There is usually a march on Main street. And later some cultural event with dances, and a food tasting of what they cook in their classes. A tasting of food healthy for diabetics.

H5: I think that since it is already such a frequent problem, it's just something else that there is in life. Like, "yes, well my grandmother is diabetic, well, my mother is diabetic, my father," and so on. Perhaps, it's just something that they see as something that just happens in life. It's what happens to a lot of people and it's not abnormal. And that is why they don't usually give it too much importance.

H5: I can speak to you from personal experience, from an associate of a friend whom they diagnosed as diabetes. It was really a psychological hit because, this person was also in the medical field, and so knew what it meant.

H5:
INT: And one more thing. Do you thing with respect to the Ministry of Health that they approach diabetes as more of an individual thing, or more a societal problem? More a public health problem or of each one?
A: I think both ways. Well, from the point of view of public health programs etc. I think that in the ministry of health there is a large consciousness that this is a serious problem.

P4:
INT: No, your family.
A: Ah, yes.
INT: Or eating right.
A: Yes, my daughter. I say, “let’s go eat”, and she says, “no mama, that’s bad for you. You eat this.” And sometimes she has a Coke and says to me, “don’t drink any.”

P6:
INT: And how do you help your sister?
F: I bring her her medicine and to the doctor when she needs. But she doesn’t like this doctor at all. I liked the doctor we had because he understood us. And now we’ve got this clown.

P7: It’s not hard. But since it is a disease that doesn’t bother you much, you feel normal. But it’s easy to start neglecting. To start eating whatever.

P7:
INT: With respect to your family, how do they help you with this disease?
P7: Yes, they help me a lot with the food stuff. They try to also consume the products that I can consume. I don’t know if…well, more than anything else, they help with this.

P7: It seems to me that it’s becoming more of society. From the same example of the soft drinks. They are making soft drinks with Splenda. Things like that, so it’s becoming more of society. Before I imagine it was more of one [the individual]. One saw how you couldn’t eat this, or because of a craving or encouragement, I eat it anyway. But now in society they have sugar-free chocolate, bread too, everything. And before there wasn’t. So, it’s becoming more of society.

P7: That they should take care of themselves because it’s a silent disease. So one has to continuously check.

Lifestyle Modification

J1: She knows that it makes her ill, but she doesn't stop drinking coca-cola, she doesn't stop eating meat, and those things.

H1: Education is the key. If there isn't education, there isn't total adherence. This is what we are reinforcing at each consult—education. Besides that we have courses that we give about how to live with diabetes.

H1: The course is done in four sessions, one each week. The first is the general aspects of diabetes, what the causes are, how the symptoms are. Then the following module is diet, the third is exercise, and the fourth complications and treating diabetes. Basically, information about surviving.

H1: The basic problem here, more with type 2 diabetes, is changing of one's lifestyle. They are people that have had a minimum of 30 to 40 years with a lifestyle of bad habits and sedentary. That is what takes a bit of work. That is why we insist on diabetes education. Because if we educate them, we will give them treatment so that they can make themselves well.

H2: That is the reason why we dedicate ourselves to therapy, focusing first on diet and exercise. And later, pharmacological questions.

H2: And we tell them that that isn't it, what they need is education. Give educational talks about modifying or changing lifestyles.

H3: Then we teach them how to eat, we teach them how to change. We watch them, we control their metabolic index. And generally, it goes well.

H5: For him it was a really important thing that he had to overcome. He changed his habits, and now he is very much about his personal health, his life, and habits, and all of that.

P1: And she said to me " you have to go to exercise, because you are too young to have this disease." I can give you medicine, you'd buy it, but that's not the thing. Because I can guarantee you five good years with the medicine. After five years, understand me here, you wouldn't die, but you would have complications. The complications would being and you'd begin to suffer from some of these complications of diabetes. So, go." Reallly I didn't do exercise and I thought that I wouldn't have to do much. So I said I'd go, and I thought about it for like 15 days. I came to try, and since that date 11 years ago, I have been with the group.

P3: Something that we didn't do before, exercise. And the exercise is basic. And it's hard for us to understand it, because we don't want to do it.

P2/P3
INT: And what frustrates you about the disease?
A: It limits me. It limits me from what I am accustomed to. And more than anything it limits my food. So many years of eating bad, but flavorful eating. Now it's very different.

C: Sometimes we still fight because of that.

P3:
C: But since "could've" doesn't exist, from here and now on we have to understand the truth. Except the quantities that they gave us in the diet are so small. Aren't they?
O: You are accustomed to eating in excess. Yes. So do you still want that, or no?
A: Not any more. Almost never, now.
C: Almost never. We fight less.

P4:
A: Beans are bad too?
M: Beans no, they are legumes. Legumes like beans and lentils in moderation. So, if you don't have meat, eat beans. But please vegetables during the day, green leafy ones. Spinach. What others do you know?
A: Challote [a type of squash].
M: No, I said leafy.
A: Leafy?
M: Yes.
A: Spinach. Verdolaga.
M: Verdolaga. What else?
A: Lettuce.
M: Lettuce, very good.
A: Cauliflower, broccoli.
M: Broccoli. You get it?

P4:
M: And how many tortillas do you eat?
A: Three sometimes.
M: Sometimes four.
A: Yeah, but I don't do more than four.
M: You have to eat two that are this size. Are we together on that?
A: Yes.
M: Don't let me down Miss.
A: No.
M: And don't eat more than two tortillas, because sometimes you eat four.
A: Yes, sometimes I eat four.

P4:
INT: And how difficult did it seem to you to care for yourself with diabetes?
A: It's just that I was used to eating everything. And coke is a craving.
INT: And that's the most difficult thing?
A: Well, for me it's that.
INT: And have you come to change your diet?
A: Later on it's that if one begins to neglect that you have a little sip, then you go down.
M: None of that.
A: No, not even a sip.

P7:
INT: When you found out you had diabetes did you look for information?
S: Yes, I looked for information about diabetes. How would my life be with diabetes. I began to look for a lot of information, to get drenched in it.

P7: Mostly because I've always been active and I've been careful with my diet, that was difficult to change. It's simply not eating sugar, and that's it.

P7: Yes, I can eat everything. There are a few vegetables that are restricted, for example potatoes. I can't consume those. Pasta, everything that is carbohydrates or flour in moderate consumption. Little fat. With meat, very lean with little fat. No sugar. And the sugar allowed by the nutritionist is Splenda. But overall, everything else I can eat like normal.

P7:
INT: And besides that how has it affected your daily life? You have your insulin routine, but apart from that?
S: Well, really it doesn't affect me much. I get up at seven or eight in the morning and the first thing I do is inject myself. After my injection I take my glucose. And that's all that I do during the day. I can go, work a bit, I work out at noon and work again in the afternoon. So in reality it doesn't affect me much.

Natural therapies

J2: And you know what many Morelianos have? Household remedies. Tea of I-don't-know-what. That, to lower your sugar a cactus smoothie in the morning. So there are a lot of myths. And, yes, we have a lot, in general Mexicans, also Morelianos, we are faithful to our remedies. In that we are really natural. But after your little water, you have a coke. Then it doesn't serve much purpose.

J3: This is largely important, and you have to write it a thousand times. Because diabetic people, more in the interior of the state believe that with herbs, that with who-knows-what, a branch of whatever...And here in Michoacán there is a large culture of traditional medicine, which is what we call it. And they believe that that cures diabetes.

H1: The others [myths] are more about alternative medicine. What we advise is that it's not prohibited, but never to abandon medical treatment. And all of the options that alternative medicine has are welcomed.

H5: I think that this can influence people to let themselves be taken more with natural remedies or what the neighbor says. They look for other help strategies or support with their illness.

P1: Because my mother, at the beginning, "there's so much to do, there's so much to do." Water, and water with lemon, with some lines of salt to quench your thirst.

Stress and Emotion

J2. Then, you have to scare them a bit. Because if not, they don't understand. If you don't say that you can die, which is true, they don't get it, they don't pay us any attention.

H2: It's undeniable that the first few interviews people come with fear, it's one more thing that I am responsible for through the education. When the finish with the doctor they come with me. And I begin to question them about their life plans in a year. Five. Ten. And there is when the fears begin to come out. But yes, it is true that there is a much more marked fear for death.

H2: And then when people know the diagnosis and you realize that you are going to die from it, the fear comes from the first instance of diagnosis, and there isn't really a real-time acceptance. It takes them months to accept what they have.

H2: One of the things that we review is the stages of depression. There we have a job when it's depression. If there is an inclination toward depression then it is important to detect it—the doctor that does the therapy consult. You are going to fall into the same depression, that you see at the psychotherapist. Fear and denial accompanies getting closer to death.

H2: I depends. For example, if it's a child they as me: "am I going to be like this all of my life?" "Am I going to be able to play sports?" Each one has their own questioning. Children focus on the future. They are not thinking about getting leg cut off. They say: "and will I be like the others? When they are older they say: "Can I get married?" "Can I have children?" And when they have evolved to a more advance diabetes: "What about the complications?" Then each one has a question to ask. And there is something else that is important: in men, they begin to worry about their sexual potency

H3: We teach them to meditate. To empty their consciousness of all of the things that they have in their heads. Some if which is tremendously bitter. And the helps them and it helps their self esteem. And well tell them that the beauty of a woman is in her personality.

H3: Because the stage of finding out that one is diabetic is a critical stage, and we have to educate in an appropriate way, with the objective of signaling surviving. Once they have triumphed in that and they move on, the education can continue. Then comes the nutrition classes, the diabetes classes, and the advise, and we go from there.

H5: I've heard a lot that people attribute their getting diabetes to *sustos*, or dislikes. I'm not sure if there is any reason that justifies it from a physiological point of view that can link to it. Or if simply you don't realize. I don't know.

P1: I found out because I felt ill, and now I know what I didn't know then, that it was called depression. An anxiety. I couldn't sleep, in other words, I felt very bad, a lot of stress. But I didn't know what it was called. Then I went to the doctor.
P1: But when, I remember that I was in bad place. I cried, cried, and cried and the doctor said, "go ahead and cry, cry until you can't cry any more". But I rested. And after that, I haven't cried

any more. I'm clam. Yes, there are times that I let go a bit, because it's a disease that sometimes does that, and in a later…[hand gesture that indicates she is fine]

P1: Here in Morelia there are a lot of diabetics. And it makes me sad, it makes me sad, but I pay attention because I've been there. Sometimes when I have a doctor's visit and I see people leave crying, desperate. Why? Because they've been informed that they have that disease. And sometimes I talk to them if I have the opportunity to approach them. "Take it easy, it's a disease that can be control, and we can live many years with it, if we know how to control it."

P3:
A: Yes, exactly. But I'm going to give you an example. There are places that we go to and there's nothing to eat. We arrive at some towns and there's nothing to eat. So what do we do?
O: And there is a solution there, and it's to wait.
A: For example, I go to Lazaro Cardenas, but from Lazaro I go to a country ranch and work for five days. It's a distance of 100km. Then what? There are no [healthy] places to be found!

P4 INT: And how has it affected your everyday life?
M: You don't get angry? You don't have hard times at home?
A: Well, no.
M: Ah, you sure?
A: Well, sometimes yes.
M: And your husband is good?
A: Well, now yes, he's good. Before he was more [trails off]… but now he's better.
M: So, now he's better?
A: Yes, yes. He drank a lot. I told him, "I don't care that you drink, [INAUDIBLE]. Drink all you want. Drink until you are tired of drinking, but don't come bothering me.

P6: Well, when I got married…we'd be together for hours, and my husband died, and she told me to come live with her and her husband. And they fought and they fought with me. And I owned my things, and they wanted me to sell my stuff. And the children…they would throw the keys to open the doors, they would go in before her. And they would throw her out. And later I would arrive and knock on the door. [INADUDIBLE] And I throw them out. I threw them right out. So then the flew to the door and the girl [the sister] was walking and they grabbed her and started beating her up like a dog. And she felt bad. And from that point on she's had diabetes. It's those animals' fault… And that's why she has diabetes. It's not from being sick, it's from nerves. It's from nerves the diabetes that she has. That's why she's neither happy nor unhappy. Because the diabetes that she has isn't from being sick. It's a conflict that she has in her body. Because of that. From "susto" [(fright)] and from "coraje" [(anger)].

Cultural/Personal beliefs

J1: Clearly, but the people of Mexico, well here in Michoacán, we are deciduous when it comes to illness. With that I am referring to those who don't give it any importance. In other words they know that it's mortal, that is treatable, and but that it's serious, but it is as if they ignore it. They ignore illness. As with cancer.

J2: I'm telling you Mexicans are "amariguistas" [fascinated with the bad , gore, or ugly parts]…Then people get scared when they talk about cutting of a hand or a foot. And I insist that it is preventable.

J2: For example there is a lot of infantile diabetes in Mexico. And the mothers believe that they aren't going to live, that they are going to die, that they are going to cut of a foot. And it's not like that.

J3: And they believe that diabetes can be cured. I can assure you that there are a lot of people who do not know that diabetes doesn't have a cure. But there are those who believe there is a cure.

H1: It varies, the people in our line of work, the same as in most parts, people are not accustomed to health education. So it varies. Sometimes we have six courses a year, sometimes four. We've never had more than six.

H1: Well, there are many myths that are still around. Like insulin can leave you blind.

H2: Ok, as Mexicans, being a little overweight and a bit chubby gives the aspect that we are healthy.

H2: For example, I have seen English senior citizens [women] who are thin, taking care of their physical appearance. They no longer have husbands because you know men die first. But it's part of the myth. And it has a lot to do with self-esteem. The fact that, well, I no longer serve any purpose. When the most important thing is to serve yourself. Also, another Mexican myth for me is the fact that if you have a healthy self-esteem, in which you recognize that you are important for yourself, and others don't get this impact, but as if you were a person out of context, then you already have a blemish. Because the older population that exists that doesn't manage the idea that health comes from self-acceptance. And if I see myself as already fat, and saying that I'm fat, I begin to say, "so what?", that's they way you want to stay. So this is a myth for me that traps men and women of a certain age, which beings in life stages.

H2: In Morelia when they advertise meetings or conferences that specifically say the word "diabetes" you will see amongst the audience, not only are doctors, nurses, or health sectors trying to register, but there are people that are fathers, people with diabetes that do it because "well, what is there now?" With a hope that it will cure them. Or "what miracle medicine are they investigating now?" And I'll take it a bit further, "I would like to be a guinea pig for a researcher, with hopes that they can cure me of diabetes."

H3: Sometimes it's hard work for them to diet because of their customs.

H5: There are people…I have some associates that don't give it much importance. They don't take care of themselves. And I think that sometimes people live with it like anything else. But not something they consider so much as a disease. It's a condition. But that's the feeling I get…really I can't answer too much there. Because I'm from another culture.

H5: And here I get the feeling that it is a little more assumed as a part of something that can happen to you in life. Just like you can be left unemployed, just like you become lame, or something like that, I don't know. There is a certain fatalism in Mexicans that things can go bad and you accept it and continue on happily.

P3:
C: They say, "I'm fat, but I'm happy." What type of mentality is that? And for example, for us being our age, it's no longer easy to lose weight.
O: Well, you have to forget that.
M: Well, yes. But for me…because I can't. I want to be a certain weight, but I still can't.