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Social Networks and the Communication of Norms About Prenatal Care in Rural Mexico

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Many normative beliefs are shared and learned through interpersonal communication, yet research on norms typically focuses on their effects rather than the communication that shapes them. This study focused on interpersonal communication during pregnancy to uncover (a) the nature of pregnancy-related communication and (b) normative information transmitted through such communication. Results from interviews with pregnant women living in rural Mexico revealed limited social networks; often, only a woman's mother or the baby's father were consulted about prenatal care decisions. However, women also indicated that communication with others during pregnancy provided important normative information regarding prenatal care. First, most referents believed that women should receive prenatal care (injunctive norm), which was conceptualized by participants as biomedical, nonmedical, or a blend of both. Second, family members often received prenatal care, whereas friends did not (descriptive norms). These findings highlight the key role of personal and social networks in shaping personal pregnancy-related beliefs and behaviors.

Pregnancy is an intensely personal experience laden with social meaning (Bute & Jensen, 2010) that differs across cultures. Interpersonal communication during pregnancy reflects unique cultural and social normative beliefs about pregnancy (Adoleye, Aldoory, & Parakoyi, 2011), and this communication with informal information networks also helps women derive their own normative beliefs (Lapinski & Rimal, 2005). This study examined pregnancy-related communication as reported by pregnant women in the Yucatán Peninsula in Mexico to better understand how normative beliefs about prenatal care are communicated.

Understanding how normative beliefs about prenatal care are transmitted in the Yucatán region is important for practical and theoretical reasons. In this region, many women do not receive prenatal care that could reduce maternal and infant mortality (Gortman, 1979). Barriers to such care include lack of resources or access, but even when these barriers are not present, women often do not seek prenatal care (Barber, 2007). One explanation for this may be the influence of normative beliefs that do not endorse prenatal care; thus, the present study focuses on how normative beliefs about pregnancy are communicated in this region. With this focus on the communication of normative information, this study makes a unique contribution to the social norms literature. Most social norms research measures already-formed norms, but this study responds to Mollen, Rimal, and Lapinski’s (2010) call to investigate the communicative processes that give rise to normative beliefs. In addition, working under the premise that culture influences normative belief formation, this study examines norms in a unique population that has seen recent increases in social isolation as a result of migration (Daltabuit & Leatherman, 1998) using interview methods. As such, this study offers a glimpse into how norms about prenatal care are communicated in a small Mexican community.

Communication and Normative Beliefs About Pregnancy

Women receive information about pregnancy through communication with informal information-sharing networks that include significant others, extended family, and friends (Tardy & Hale, 1998) and from formal information sharing from health care providers (O’Keefe, Boyd, & Brown, 1998). This communication shapes a woman’s pregnancy identity and can affect her willingness to engage in consistent prenatal care behaviors (Campbell, Mitchell, Stanford, & Ewigman, 1995; Klaus, Kennell, Robertson, & Sosa, 1986). One aspect of this identity-shaping communication during pregnancy is the sharing of normative information regarding prenatal care. Information about attitudes related to prenatal care, or injunctive normative beliefs, is often shared as advice (Tardy & Hale, 1998). Repeated exposure to this type of informal interpersonal communication can give rise to normative beliefs about appropriate behaviors for mothers-to-be (Cline, 2003).
Perceived social norms about health are formed through everyday interpersonal communication about health and observation of others' behaviors (Lapinski & Rimal, 2005). Research demonstrates that what we see others do (i.e., descriptive norms) and what we believe they think we should do (i.e., injunctive norms) influence health and environmental behaviors (Cialdini, Reno, & Kallgren, 1990; Park & Smith, 2007; Rimal, 2008; Rimal & Real, 2005). Moreover, the greater the salience of particular aspects of social norms, the stronger their influence is expected to be (Cialdini et al., 1990). The literature has identified the direct, moderated, and mediated effect of norms on a host of health behaviors, including alcohol consumption, exercise, organ donation, and environmental conservation (see Mollen et al., 2010, for a review; Rimal, 2008). Most studies of norms, however, focus on the effect of already-held normative beliefs rather than on the nature of communication that may give rise to and shape such beliefs (Mollen et al., 2010). Furthermore, given that cultural dynamics should influence normative beliefs, studies of social norms can take into account the cultural context in which normative information is conveyed by using methods that allow for participants’ conceptualization of key concepts. As such, using semi-structured interviews, this study focuses directly on interpersonal communication that conveys normative information in order to better understand norm formation.

The experience of pregnancy provides a rich context for examining the communication that generates normative beliefs about prenatal care. First, because pregnancy is a time of uncertainty (Matthias, 2009), the importance of social networks is heightened (Albrecht & Goldsmith, 2003), and normative information is more influential (Cialdini & Goldstein, 2004; Lapinski & Rimal, 2005). Second, pregnancy is a health experience indicated by a unique physical change in a woman’s body. Like other visual ‘marks’ (Goffman, 1963), this visual cue might prompt communication about pregnancy that reflects the social group’s prevailing values and beliefs about pregnancy (Aubrey et al., 2008).

The Yucatán region of Mexico is characterized by rapid population flux, as a result of migrant work opportunities, and by the relatively recent introduction of biomedical practices in areas where indigenous health practices are reportedly widely used (Daltabuit & Leatherman, 1998). Given shifts in the population and in the availability of multiple forms of prenatal care in this region, normative beliefs about prenatal care may be in flux. Because of variability in access to such care, there is a potential for limited information about behavioral prevalence. That is, because access to prenatal care is uneven, people may have few examples of others around them accessing prenatal care and as such, the descriptive norm may be weak. Moreover, the nature of injunctive norms in this region and how those norms are communicated are unknown; prenatal care may or may not be a valued behavior in this area. With mixed normative information comes ambiguity about prenatal care behaviors. Ambiguity about behavior may increase the drive to seek or provide normative information as well as increasing the influence of normative information about that behavior (Cialdini & Goldstein, 2004; Lapinski & Rimal, 2005). Thus, there is reason to suspect that normative information about prenatal care may be communicated in this population. In a migrant population in which social ties are weak or continually changing, the opportunity to learn about norms through communication may be limited. Thus, limited communication about prenatal care may dramatically shape normative beliefs about this behavior, making an understanding of the nature of that normative information vital.

For this study, interviews were used as the method in order to limit potential biases about conceptualizations of social norms and prenatal care. In these interviews, pregnant women were asked whether they communicated with anyone about their pregnancy and its care. We addressed the following research questions to understand how interpersonal communication about pregnancy conveys social normative beliefs:

Research Question 1: With whom, if anyone, do pregnant women talk about their pregnancies?
Research Question 2: What is the nature of women’s communication about their pregnancies?
Research Question 3: What are women’s beliefs about the behaviors associated with a healthy pregnancy?

Method

Study Site

This study was conducted in an indigenous community near Playa del Carmen in the southeastern region of the state of Quintana Roo in the Yucatán Peninsula (population 1,955,577; Instituto Nacional de Estadística y Geografía [INEGI], 2010) of Mexico. The local economy is driven largely by the tourist industry, which has resulted in a large influx of migrants from central Mexico seeking employment (Daltabuit & Leatherman, 1998). Health care facilities in this region are sparse and underdeveloped, often lacking adequate resources (Daltabuit & Leatherman, 1998). More than 25% of the Yucatan population is not covered by any health services (Instituto Nacional de Estadística y Geografía, 2010).

The study site was a semi-rural community near Playa del Carmen, Mexico, called Nic-te Ha. A small nonprofit holistic health clinic operated in the center of this area, which integrated biomedical, traditional, and complementary medical practices. The clinic occasionally offered limited services for pregnant women, including monthly exams and prenatal care classes. These services were often offered free of charge by allied health care providers, midwives, and medical doctors.

One of the authors of this study (P. L.) has been affiliated with this clinic for over a decade, and has built relationships with the clinic director as well as members of the community. This person, along with a team of doctors, has provided numerous medical procedures and speech therapy sessions at no cost for children with cleft lip and cleft palate in the region. These congenital craniofacial
malformations can often be prevented through prenatal care practices (Murray, 2002), which was one reason why the team was interested in learning about current prenatal care practices, beliefs, and social norms in this region.

Participants

Twenty-seven pregnant women were recruited through a promotora network linked with the clinic and through word-of-mouth household recruitment in the neighborhoods near it. In Mexico, promotoras are women employed by the government to diffuse public information to local community members (Ramirez-Valles, 2001). Participants were 16–32 years old ($M = 22.62$, $SD = 4.85$) and had between 0 and 4 children ($M = 1.12$, $SD = 1.05$). Most (89%) reported having a live-in husband or boyfriend who was the father of the child with whom they were pregnant. Women reported having between 1 and 11 ($M = 3.52$, $SD = 2.26$) people living in their household and most (81%) were not employed. Most participants reported middle school (56%) or elementary school (37%) education; two women reported completing some time at a university. All reported Spanish as their primary language; 6 women reported having Mayan heritage.

Data Collection Procedures

Interviews were conducted by three promotoras, who were also allied with the local clinic and coordinated community engagement activities to support the local health infrastructure. The interviews were semi-structured; protocols were designed to allow interviewers to ask follow-up and clarifying questions. The term prenatal care was not used in the interviews; rather, we used the Spanish translation of care for your pregnancy, and participants were probed for their definitions of its meaning. Thus, the interviews did not assume a predetermined definition of prenatal care, but rather allowed participants to explain—in their own words—the activities they do during pregnancy to ensure a healthy baby. The first author trained all interviewers on the protection of research participants and the interview protocol.

The interview protocol was developed in English, translated to Spanish, then back-translated to English to check for accuracy and avoid biased terminology. The interview began with an overview of the purpose of the study and demographic questions in order to begin to build rapport. Next, a number of questions asked generally about the participant’s pregnancy experience, including their current pregnancy and when they learned they were pregnant. Participants were asked about prenatal care beliefs and health behaviors generally. Then, interviewers specifically asked about prenatal care practices by asking questions such as “Have you ever seen anyone for care about your current pregnancy?” and “What happens when you visit this person?” To elicit participants’ ideas of what might constitute prenatal care, interviewers then asked questions such as “How do you know when a baby is healthy?”, “What things that happen during a pregnancy lead to a healthy [unhealthy in the following question] baby being born?”, and “Are there things that you are doing while pregnant to try to make sure you have a healthy baby?” Once prenatal care behaviors were discussed, interviewers turned to descriptive normative beliefs by asking questions such as “Have your friends received care during their pregnancies?” and “Have women in your family received care during their pregnancies?” To learn about perceived injunctive normative beliefs of partners or husbands, family members, and friends, interviewers asked questions such as “Have you talked with your [referent] about your pregnancy?”, “What types of things do you talk about?”, and “Does your [referent] believe it is important for you to get care for your pregnancy?” Several questions asked about decision-making processes, and one question asked about the role of spirituality or religion in the pregnancy. The full interview protocol is available from the first author.

The protocol was pilot-tested with 5 pregnant women in the community; these interviews were not included in the final data analysis. Interviews were conducted in Spanish in private rooms at the clinic or in local households and lasted approximately 1 hour each. After the interview, participants were given incentives in the form of prenatal vitamins and information about local prenatal care services and the benefits of folic acid. Interviews were recorded with digital voice recorders, then transcribed in Spanish, translated into English, and back-translated by native Spanish speakers to check for translation accuracy. All study procedures followed institutional review board protocols.

Data Analysis Procedures

Thematic analysis of the interview data used inductive and deductive coding approaches to develop themes (Braun & Clarke, 2006). First, a codebook was developed inductively by the second author, using the data from the interviews. The responses were broken down into thought units (subject-verb pairings) so that a response to a question could contain more than one thought unit. Two independent coders used the codes from the inductively-generated codebook to analyze the interview data. Intercoder reliability for this coding was $\kappa = .86$. The second author and third author, who was one of the original coders, then reviewed the coding in order to combine categories, generate new codes, or delete unnecessary categories, so that the themes provided the best reflection of patterns in the complete data set. In this round of coding, coders reached 100% agreement. This coding allowed the researchers to calculate frequencies of response types for each interview question and gain a sense of the overall content of the participants’ responses.

Then, the first author used a deductive approach to understand specific elements of the responses in relation to the research questions posed in this study. Guided by the idea that communication during pregnancy shapes normative beliefs and personal identity (Campbell et al., 1995; Klaus et al., 1986; Tardy & Hale, 1998) the first author analyzed the transcripts for responses that dealt with these issues. The themes generated in this portion of the analysis were not constrained by particular interview questions (as they were
in the inductive coding), but were developed on the basis of responses given to multiple, related interview questions.

Results

This study examined the nature of communication about pregnancy (Research Question 1), the people involved in such discussions (Research Question 1), and the normative beliefs about pregnancy that were communicated through such interactions (Research Question 3). The major themes evidenced in these data for Research Question 1 related to limited communication with a small number of actors, including (a) social isolation and (b) solitary decision making. The nature of that communication included decision making and advice from husbands or boyfriends, female family, and friends (Research Question 2). Descriptive and injunctive normative beliefs (Research Question 3) indicated that prenatal care includes biomedical (e.g., visits to doctors or clinics) and naturalistic (e.g., self-care, music therapy, massage; see Office of Minority Health, 2004) elements, an idea that surfaced in normative information and self-described behaviors.

Limited Communication

In general, women talked to few people about their pregnancies (Research Question 1), and their decision making about pregnancy-related concerns also reflected a limited number of interactants, if others were involved with decision making at all.

Social Isolation

Many of the women in this study reported scant communication with others about their pregnancies while they were pregnant. For example, none of the women reported talking to someone when they suspected they were pregnant, and only 3 women reported speaking to their husbands or boyfriends when they confirmed their pregnancies. When women suspected they might be pregnant, they were likely to go to the doctor, have an emotional response, or take a home pregnancy test without talking with someone about it. Some women indicated that they had very few people to speak to about their pregnancy; they were socially isolated. Participant 7 said, “I know almost no one,” and Participant 21 similarly said, “I alone make my decisions.” In addition, 4 women said they had no one they could trust; 11 women said there was no one outside of their immediate family they would trust for information about their health.

In the midst of this social isolation, some participants turned to religion as an outlet for communication. Many participants (n = 19) reported that religion was important to them. Participant 14 said, “I need [religion/God] because… I don’t talk with anybody else.” Participant 2 echoed this sentiment, saying, “When we feel alone, praying/asking him [God], one feels better.” Religious practices, such as relying on God for the baby’s health, also allowed women to remain isolated during pregnancy. For example, Participant 16 said, “God is the only one that can bring your baby well, [He] is the only one, there is nobody else.” Indeed, although religious belief is often experienced and expressed within a religious community where interpersonal connections are formed (Blanchard, Bartowski, Matthews, & Kerley, 2008), religious belief did not seem to be characterized by community ties as much as by individual connection to a deity.

When women did talk to others about their pregnancies, they often did so in a limited fashion, speaking mostly to a husband or boyfriend or to a female relative (often their mothers) (Research Question 1). Women who spoke primarily to their mothers about their pregnancy were typically those without boyfriends or husbands. Less commonly, women reported talking about pregnancy to other family members, friends, other pregnant women, or medical personnel; few women mentioned friends with whom they communicated. In terms of frequencies of these behaviors, most women spoke largely to their spouse about their pregnancy (63%); others spoke to their mother (48%) and a few to friends (30%). Some participants mentioned that they were often only able to speak with mothers or other female relatives over the phone because of social isolation brought about by immigration.

Solitary Decision Making

Social isolation was especially pronounced in women’s reports of pregnancy-related decisions (Research Questions 1 and 2). Half of the participants reported making all decisions about their pregnancy absent communication with others. Of those who did report speaking to others (mostly husbands or boyfriends), most of their communication and decision making revolved around issues of whether or not to receive biomedical prenatal care (or how often to do so), whether or not to undergo certain medical procedures, and whether or not to change providers. In some cases, the other person with whom the decision was made played a dominant role in the process, as is demonstrated by the following example. Participant 4 identified an instance in which she and her husband made a difficult pregnancy-related decision (that is, she identified it as shared decision making):

Well on the occasion when we went to the gynecologist… they told me that I had to have an abortion, because my health was in danger, and I went outside [to see my husband]. “What happened?” he said. [and I said], “Look, my health is at risk…” And the syringe was in [the doctor’s] hand. My husband said, “I don’t know. No, I want to give life to my son,” and that was it, we signed the papers in which we assumed responsibility.

Communication About Prenatal Care and Normative Beliefs

The nature of women’s communication about prenatal care and their beliefs and behaviors associated with health pregnancy are subsequently described in terms of descriptive normative beliefs and injunctive normative beliefs. Descriptive normative information was gleaned through observation and interpersonal communication about behaviors. Injunctive normative information was shared
through advice but also in the context of decision making. In both cases, communication about biomedical and naturalistic prenatal care was reported.

**Descriptive Normative Beliefs**

The ability to learn about descriptive norms for prenatal care in this sample appeared to be limited because of the social isolation and solitary decision making that many women expressed. Despite such social isolation, many of the women in the study had received descriptive normative information from family members and friends. The descriptive norm for receiving formal care during one’s pregnancy was mixed (Research Question 3). Some \( n = 3 \) participants’ family members had talked with them about using a blended approach (naturalistic and biomedical) to prenatal care. Almost half of the women reported that family members \( n = 11 \) or friends \( n = 2 \) told them they had received formal medical care during their pregnancies, but a number of other participants \( n = 12 \) reported that their friends did not receive formal prenatal care. Three participants shared stories that suggested communication with others reveals a descriptive norm eschewing biomedical or other formal prenatal care. For example, Participant 11 said:

> There are a lot of people who say, ‘[The baby] is here [in my womb], and I don’t care if I go to the doctor, to go to an examination, or to see how the baby is doing, nothing.’ They simply leave it alone; they say ‘it will be born,’ so they leave it as is.

This comment reflects a sense that many of the participants voiced—that pregnancy is not a medical condition but rather a natural occurrence that can be experienced in the absence of medical care or intervention. Because women’s communication about pregnancy stressed its naturalness, communication about norms for care during pregnancy also reflect the idea that medical care or intervention is not necessary for a successful pregnancy unless there is evidence that greater concern is warranted.

Although medical care or intervention was not stressed as central to care during pregnancy, some women’s communication about pregnancy did reflect the practice of receiving pregnancy care from trained caregivers such as midwives. Participant 8 (who did seek biomedical prenatal care) described talking to her female relatives about their pregnancies, saying, “Always [my female relatives] visited a midwife [for prenatal care], they didn’t visit a doctor.” Participant 26 also noted a descriptive norm of midwifery, but pointed out that she does not follow that norm: “A lot of people have [midwives], they trust in the midwives, but I don’t, I haven’t used midwives.” Thus, it is clear from these women’s responses that the communication about descriptive norms regarding prenatal care is mixed. Women’s communication about prenatal care norms revealed mixed norms in terms of the prevalence of others receiving formal prenatal care as well as the source of such care. Although some women do not receive formal prenatal care, in part due to a conceptualization of pregnancy as a natural—rather than medical—condition, many women do receive formal care during their pregnancies. Women’s communication about the descriptive norm for formal care during pregnancy reflected a broad approach that could include biomedical and nonbiomedical caregivers, such as midwives and other approaches to self-care, which were most often described in terms of women’s own beliefs and behaviors.

**Attitudes and Injunctive Normative Beliefs**

Every participant \( n = 27 \) expressed positive attitudes and beliefs about prenatal care (Research Question 3). As Participant 9 stated, “I go to the doctor because I want to, in other words because I know that I should go.” Women felt that prenatal care is “something that all the women should have” (Participant 13). Each woman in this study believed that it was important for women to engage in prenatal care (broadly defined) during pregnancy, “to know how the baby is, in which conditions it is coming, if it is well” (Participant 3). Specifically, participants associated conscious care-taking efforts while pregnant with a healthy pregnancy. Communication about injunctive norms contrasts sharply with the communication about descriptive norms. When women communicated about descriptive norms for prenatal care, they focused on whether or not a woman received formal care during her pregnancy. However, when women communicated about the injunctive norm for prenatal care, they conceptualized prenatal care more broadly—including formal care and informal care (i.e., behaviors that the mother engages in to ensure a healthy baby). This may account for the discrepancy in communicated descriptive and injunctive norms for prenatal care. The discrepancy appears not to be between normative beliefs and behaviors, but rather between the ways that prenatal care is differentially conceptualized in communication about descriptive and injunctive norms for prenatal care.

Communication about injunctive norms for prenatal care included discussions of formal and informal modes of care (Research Questions 2 and 3). Specifically, women learned about injunctive norms for prenatal care when mothers, husbands, and female friends communicated advice, solicited and unsolicited, concerning whether they should see a medical professional for care and what behaviors they should enact or avoid.

**Injunctive Norms for Seeking Medical Care.** When asked directly about what referents think they should do, it became clear that many women’s husbands, female family members, and friends communicated a positive injunctive norm for receiving medical care during pregnancy. Thirteen women’s husbands communicated a positive injunctive norm for receiving formal, medical prenatal care. Fourteen women said that their female family members, most often mothers, communicated a positive injunctive norm for visiting a doctor or midwife during pregnancy. For example, Participant 7 said, “Yes, [my mother] always tells me [to see the doctor].” Seven women said their friends communicated this positive injunctive norm for visiting someone during pregnancy. For example, Participant 4 said that her friend “tells me to go to the doctor now, to tell him everything that
Research participant, quoted: "My husband and I had to talk about the decision to seek prenatal care. He was concerned about the cost, but I felt that it was important for our baby's health."

The other doctor gave me some medication for hip pain...But my husband told me, if you feel you are pregnant, and if your mom told you those are the symptoms, do not take it, even if it hurts...[He said] they might hurt you or the baby if you are pregnant.

Just as other participants' husbands and mothers communicated conflicting injunctive normative information about receiving medical care during pregnancy, this participant's family and physician communicated conflicting injunctive normative information about her behaviors during pregnancy.

These data suggest that the communication of normative information is not a straightforward or uniform process. Within any given community or social network, a variety of descriptive and injunctive norms may be communicated about a given topic. Community members' communication may reflect competing descriptive and injunctive norms and competing conceptualizations of the behavior itself. As the data from this study suggest, communication about norms for medical care during pregnancy reflect competing descriptive norms (that women in the community do and do not receive medical prenatal care), competing injunctive norms (that women in this community should and should not receive medical prenatal care), and in some cases, limited information about prevalence and normative perceptions of others. In addition, communication about descriptive norms for prenatal care limited its conceptualization only to medical prenatal care, whereas communication about injunctive norms for prenatal care included medical prenatal care and informal self-care behaviors for mothers.
Discussion

Interviews with pregnant women from Playa del Carmen, Mexico revealed the interpersonal communication patterns and content that give rise to normative beliefs about prenatal care. Of particular interest for communication researchers is the fact that many women reported experiencing social isolation, but other women reported receiving advice, normative information, and support through communication with select referents such as husbands or female family members.

Participants reported a limited number of people with whom they talked about their pregnancy; the majority of participants indicated that they spoke to no one. This limited communication stemmed from having small social and familial networks nearby. Beyond their spouses or partners, women’s social systems were characterized by few or no friends in the area and geographic distance from immediate or extended families. Although the causes of this isolation are complicated, it may be partially explained by the fact that the women migrated to this region for economic reasons. Small social networks might also be a function of cultural norms for female role behavior (Galanti, 2003) or of the competing demands associated with motherhood common in all societies. Limited pregnancy-related interpersonal communication may simply indicate that pregnancy is not something that people in this community are comfortable or willing to talk about. This finding is consistent with work in other health domains (HIV prevention) where norms for silence regarding a behavior (engaging in safer sex practices; Elwood, Greene, & Carter, 2003) mean that normative beliefs are not widely shared. In might also be indicative of the view of pregnancy as a normal and, hence, taken-for-granted part of life for participants.

From the standpoint of social norms theory development, this finding has a number of implications. Social isolation may affect the development of descriptive and injunctive normative beliefs in varied ways. It may be the case that limited social networks make the normative influence of any one actor very strong. If much of one’s information about others’ behavior emanates from a single source, it is undiluted by information from other people and, therefore, may strongly affect personal beliefs. In contrast, without confirmatory information from multiple sources (i.e., the multiple source effect), normative perceptions about any issue may be relatively weak because they are not reinforced by normative information from other sources.

Because many participants lacked quality social networks during their pregnancies, they lacked social support and an informational network that could transmit key prenatal care information (Albrecht & Goldsmith, 2003). The participants reported that this absent network affected the nature of their pregnancy-related decision making. Their decision making about pregnancy occurred with information from few people, and because over half of the women reported that they were not receiving regular, formal biomedical care for their pregnancy, the information received from social networks appears to have played a critical role in decision making. Since previous research demonstrates that receiving information from a variety of people increases the likelihood of receiving accurate information (O’Keefe, Boyd, & Brown, 1998), the social isolation experienced by the participants may also indicate decreased likelihood of receiving accurate prenatal care information.

Social isolation and access issues associated with the local medical system mean that observationally derived prevalence information was limited. Furthermore, descriptive normative information about the prevalence of prenatal care behavior learned through direct communication with referents was mixed. Participants’ communication with friends revealed that most of their friends had not received biomedical prenatal care, whereas participants’ family members communicated that they had received biomedical prenatal care. Thus, through communication with different referent groups, women in this study learned different prevalence information about prenatal care. In addition, the data from this study indicated that participants spoke about prenatal care with family members more often than friends. The potential for differential normative influence from different referent groups is worth additional investigation.

Injunctive normative beliefs about prenatal care, both biomedical and naturalistic, were positive and more consistent across interviews than were descriptive norms. Every woman in the study reported a positive attitude toward receiving prenatal care, and most people with whom the participants communicated expressed the belief that the woman should receive prenatal care. People in this community believe that getting care is important, but few women receive prenatal care; injunctive and descriptive norms were contradictory in this case. Future research should investigate issues of contradictory norms to understand how discrepant injunctive and descriptive norms develop and why communicated injunctive norms may go against the descriptive norm in the referent group. In this case, injunctive norms were conceptualized around a broader definition of prenatal care than were descriptive norms.

Limitations

Although these findings address an important call for deeper understanding of the communication leading to the formation of normative beliefs, this study is not without limitations. The most important limitations in this study were the nature of the interviews and of the data collection. Although significant effort was put into training the interviewers and familiarizing them with the protocol, our use of cultural insiders meant that none of the interviewers were professionals. As such, there was variable implementation of the protocol across interviews. Some interviewers were more skilled than others at probing for additional information from the participants. In several cases, the interviewers did not clearly articulate the questions, so they were asked incorrectly or skipped. These challenges, inherent in collecting interview data in a field setting, negatively affected the depth of information gleaned from this study. This challenge is inherent in field data collection and one we took steps to resolve.

The responses of participants may also be a product of the social environment in which many of the interviews took
place. Although the interviews took place in private or semi-private rooms in homes or the clinic, sometimes participants were accompanied by a family member during the interview, or their responses were within hearing distance of others, despite our best efforts to avoid these situations. In this region, it is common for young women to be accompanied by their husband or older women, particularly to OB/GYN visits (Tatum, Rueda, Bain, Clyde, & Carino, 2012) and some were not willing to be interviewed without this person present. This lack of privacy may have limited the depth of information participants were willing to share with the interviewers.

This article represents an exploratory description of the communication that shapes pregnant women’s normative perceptions about behaviors associated with their pregnancies. It identified the salient normative referents and explored the nature of women’s communication with these referents. It examined the nature of communication about pregnancy and descriptive and injunctive normative beliefs. These data can be used as the basis for further understanding the role of interpersonal communication in norm formation.

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