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TRIP REPORT: GUATEMALA

September 30 - October 5, 1990

Mary Ann Anderson
Health Services Division
Office of Health
Agency for International Development

Contract # DPE-5966-Z-00-8083-00
Project # 936-5966

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TRIP REPORT

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The purpose of my trip to Guatemala was to: (1) review MotherCare Project-assisted activities with INCAP, and (2) become familiar with breastfeeding promotion activities of La Leche League and the National Breastfeeding Commission. My itinerary is in Annex 1 and list of contacts in Annex 2.

APROFAM (Asociacion Pro-Bienstar de la Familia de Guatemala)

APROFAM, an IPPF affiliate, is a private organization which USAID assists to provide family planning and MCH services in clinics throughout Guatemala. I accompanied Jayne Lyons of USAID to an appointment she had with the Director, Dr. Santiso. Dr. Santiso is interested in activating the Safe Motherhood Initiative in Guatemala. He attended the Meeting of Interested Parties for Safe Motherhood at WHO/Geneva in June 1990. He has been in contact with Jill Sheffield of Family Care International about the possibility of holding a regional Safe Motherhood advocacy conference in Guatemala in March 1991. On a recent visit to the "Menos y Mejores" integrated family planning project in Mexico, Dr. Santiso was very impressed and would like to adapt the approaches used to stimulate community participation in Guatemala.

I toured the APROFAM facilities and observed clean and orderly prenatal, MCH and family planning services being delivered to a clinic full of patients. I was disappointed to find no educational materials on breastfeeding to give to mothers. In fact, one of the physicians said that they recommend that mothers bring baby bottles filled with sugar water to offer to infants during immunization sessions in order to comfort the infants. The maternal record used during prenatal visits (see Annex 3) could be improved by replacing it with the more comprehensive CLAP (Latin American Perinatology Center) record which has been successfully tested in Guatemala by Dr. Eric Boy, INCAP, and now approved by the Ministry of Health for national use (see Annex 4).

APROFAM had just opened in September a clinic for screening and treating sexually transmitted diseases (STD including chlamydia and HIV-AIDS) in a separate building.

In contrast to their other facilities, the STD clinic was staffed but devoid of patients. The clinic is counting on word of mouth to advertise their services and is quite apprehensive about having the negative image of STDs affect their acceptance rates for family planning and MCH services. However, some way should be found to utilize the excellent STD clinic fully since it is well known that there is a big STD problem with serious consequences.

AGES (Asociacion Guatemalteca para Educacion Sexual)

I accompanied Jayne Lyons to a meeting she had with the director of AGES. This association provides sex education and counselling on family planning to teenagers and adults. It does not offer family planning services but refers interested clients elsewhere. The association also provides education on AIDS prevention and on maternal and child health. They have an innovative program to encourage Mayan Indian children to attend and finish school.

BREASTFEEDING ACTIVITIES

La Leche League (LLL) got started in Guatemala by a Canadian expatriate 15 years ago and currently has 4 mother support groups among middle and upper class women (3 groups in Guatemala city and 1 in Quetzaltenango) with 12 leaders. The League has an AID/Washington (FVA) child survival grant to adapt their successful breastfeeding promotion through mother support groups among the middle-class to urban slum women of Guatemala and Honduras. The three-year grant will end in September 1991. Mary Anne Stone-Jimenez is the director of the Guatemala project which plans to establish 30 mother support groups and train 120 breast feeding advocates (4 per group) to run the groups. A mid-project evaluation of the LLL grant was just conducted by Sandy Huffman and Rebecca Magalhaes, but the report was not yet available. To date 12 groups have been established in 5 communities. Each group covers an area of approximately 5,000 population. Some of the mother support groups formed early in the grant in collaboration with the Salvation Army have already disbanded because the advocates recommended by the Salvation Army weren't from the community they served. Five of the middle class mother support group leaders are assisting the child survival grant funded efforts to adapt the LLL approach to marginal urban slums.

Many of the breastfeeding advocates who have been identified and trained under the grant are midwives. However, contrary to expectation the mothers enrolled in the breastfeeding support groups use these midwives for pre- and postnatal care but go to the government hospital to deliver their babies. This is because the hospital is "free", and the midwives charge something. The breastfeeding advocates receive 20 hours of training and are volunteers who receive

no pay. They must hold one group meeting per month and be on call to advise mothers as needed. An excellent pictorial manual on breastfeeding promotion has been developed by LLL for the breastfeeding advocates. They are printing it to share with other organizations. The League also has had success using cloth posters to stimulate group discussion by mothers on different breastfeeding practices.

Baseline data on breastfeeding practices collected for the project by INCAP showed 56% of the mothers exclusively breastfeeding children 0-4 months of age. However, this appeared to be an overly optimistic picture based on actual field observations of LLL and they therefore decided to conduct a more in depth KAP study with the assistance of Dr. Marcelo Castrillo, Johns Hopkins University. This survey revealed a far more negative situation in which 93% of all breastfed infants were receiving other liquids in the first four months of life. Indeed, by the end of the first month of life, 70% of all breastfed infants were receiving other liquids. Of these suboptimally breastfed infants in the first month of life, 63% had received other liquids during the first week itself. The LLL project staff are probing into the discrepancies between the two surveys. But the most likely explanation is the fact that the INCAP survey did not ask mothers whether water was given to the infant. The recent in-depth KAP survey also found that of those ever breastfed, 42% were no longer being breastfed at 6 months of age.

The USAID Mission through a buy-in to the International Institute for Studies of Natural Family Planning of Georgetown University is funding a joint activity with LLL to conduct training workshops on the lactational amenorrhea method. One will be held for the medical profession in February 1991, followed by six additional workshops for other community workers,

The League is planning to submit a new proposal in the next round of child survival grants competition to continue their work in Guatemala for another three years. They foresee a role for LLL as an advisor to other PVOs in how to establish breastfeeding mother support groups among the women these other PVOs already work with. Since other PVOs have much more infrastructure than LLL, this may be a more cost effective approach than LLL trying to establish and sustain groups in communities where LLL has no infrastructure or established relationship.

The Guatemala National Breastfeeding Commission was formed in 1979 and established by law in 1981. Since it is outside the Ministry of Health, the Commission, comprised of various government ministries including health, education, labor, and non-governmental organizations, has been stable and impervious to turnover in government staff. In 1987,

Guatemala passed legislation putting into effect the International Code of Marketing of Breastmilk Substitutes.

Dr. Ruth de Arango, Technical Advisor to the Commission, attended the international policymakers meeting on breastfeeding in Florence, Italy in August 1990. She shared a number of educational materials developed by the Commission with me. She also showed me a very useful video, manual and laminated flip chart developed by UNICEF for training traditional Mayan Indian birth attendants. The Commission's primary work is in advocacy, hospital reform, and workplace support systems for breastfeeding women. Guatemalan law provides maternity leave of 30 days prenatally and 45 days postnatally, plus one hour/day nursing breaks when back on the job. (Jayne Lyons of USAID has urged that USAID review all its projects to assure that they are compliant with national legislation of the host country on maternity leave and nursing breaks, and make greater efforts to facilitate breastfeeding by working women. This should be a WID concern and is of relevance to all USAID missions.)

Through its efforts the Commission reports that 100 percent of government hospitals now have "rooming-in." This is not true of private hospitals which are not subject to regulation. Norms for proper lactation management have been developed by the Commission and posted in hospitals and human milk banks have been established in a number of hospitals.

The Commission is currently conducting a study of the Kangaroo Mother Method (KMM) of care for low birth weight babies which consists of breastfeeding and skin-to-skin contact with their mothers at two Guatemala City hospitals: Roosevelt and the Instituto Guatemalteco de Seguro Social (IGSS). One hospital is serving as a control for the other, with a cross-over design after six months. MotherCare should learn more about this study since they too are evaluating the KMM in Ecuador. Dr. Arango mentioned that in the original KMM in Colombia, infants were given guava juice in addition to breastmilk. In Guatemala they haven't found this necessary and feed infants exclusively on breast milk.

Dr. Arango took me to see "rooming-in", the human milk bank, and KMM at the Roosevelt Hospital in Guatemala City. Their approach to lactation management was very impressive.

FIELD TRIP TO QUETZALTENANGO

Four districts in the altiplano department of Quetzaltenango are the site for an intensive demonstration project by INCAP with MotherCare assistance. An alternative strategy for the training of traditional birth attendants, and the management and referral of high risk obstetric and

neonatal cases by TBAs and government health providers will be tested and compared to control districts. Jayne Lyons of USAID and Barbara Schieber and Junio Robles of INCAP accompanied me on the field trip. Our first stop was the referral and teaching hospital, San Juan de Dios, which serves the entire department of Quetzaltenango and which will play a pivotal role in caring for high-risk referrals. Our guide was a neonatologist, Mario Mejia, who recently joined the hospital staff and is committed to improving services there. The hospital faces the usual problems of crowding and shortage of staff. Since the health centers have no facilities for delivering babies, all high-risk deliveries for the department must be referred to this hospital. Difficulties of long distance and lack of transport to the hospital will have to be overcome.

The hospital's approach to lactation management was disturbing, especially after having seen the well run Roosevelt Hospital in the capital. Although the national Breastfeeding Commission's norms, which call for exclusive breastfeeding, were posted on the hospital's walls and although babies and mothers roomed together, according to the nurses all infants are given infant formula in bottles at night. There was ample evidence of bottles with formula on the nightstands and a supply of infant formula (NAN by Nestle) in the store room. The nurses acknowledged awareness of the norms but said that it is too cold in the highlands and mother are too tired to breastfeed at night. The human milk bank was defunct and low birth weight babies were being given only infant formula and no breast milk. One good feature was that the hospital does not routinely give glucose water to newborns.

Medically induced introduction of mothers to bottle-feeding before they even leave the hospital has very negative repercussions on breastfeeding practices and infant health and survival after discharge. If the MotherCare demonstration project is to succeed, the hospital's approach to lactation management will need to change. While referring high-risk deliveries among traditional women to the hospital and saving the mother's and infant's lives is laudable, simultaneously introducing partial or total bottle-feeding which ultimately endanger the infant's survival in the harsh, impoverished rural village environment is unsatisfactory. In fact, it is these high risk cases, low birth weight babies, etc. that need breastfeeding the most.

MotherCare and USAID/Guatemala will need to assist interventions to improve lactation management. Dr. Mejia has already requested technical assistance to review the hospital's norms for maternal and neonatal care by Dr. Roberto Sosa, a U.S.-based Guatemalan neonatologist who is a strong advocate of breastfeeding, and who is well respected

among pediatricians in Guatemala. The Breastfeeding Commission should also be encouraged to review the lactation management practices of all rural hospitals and take steps to enforce the national norms.

Dr. Mejia shared statistics on the hospital's deliveries over the past year. There were 2900 deliveries per year or about 250 per month. Of these 19% were low birth weight and 6% were premature. Fortunately only 1.8% of the infants born in the hospital were in the very low birth weight (VLBW -- <1500 g) category. This low rate of VLBW is encouraging because 1500 g is also the cut-off below which infants have difficulty sucking and require tube feeding. This means that virtually all the low birth weight infants should be able to suckle directly from their own mother's breast and not need expressed breastmilk, nor to be bottle-fed, as is the hospital's current practice.

The mortality rate of newborns in the hospital was 3.3% with the following main causes: asphyxia (22% of deaths), sepsis (20% of deaths), immaturity (20% of deaths) and meningitis (7% of deaths). Of the newborn deaths 13% were in infants with birth weight >2500 g, 20% in infants with birth weight from 2000-2500 g, and 67% in infants with birth weights <2000 g.

Several other hospital procedures for neonatal care also need improvement and should be tackled with MotherCare assistance. After infants are born they are cleaned and kept alone (attended by a nurse off and on) for two hours in a "transition room" before being given to their mothers so that they can be "stabilized". This interferes with immediate initiation of breastfeeding (within one hour of birth), denying the mother the beneficial effects of lactation on reducing postpartum bleeding, and denying the baby of comfort, nourishment, and anti-infective properties in colostrum. Many of the infants left alone in the transition room were crying violently which certainly does not contribute to their stabilization or well-being.

Mothers of low birth weight babies are not allowed to breastfeed them, nor even to enter the room and hold or see their baby in the incubator. In fact, one of the accomplishments Dr. Mejia was most proud of was his success in installing a window between the hall and the neonatal intensive care unit so that parents can at least peer in and see their babies. Several weeks of neonatal intensive care devoid of any parental involvement does not permit any bonding, deprives the infant of all the benefits of breastmilk, and ultimately jeopardizes the prospects for survival and normal development of the low birth weight baby.

When neonates born elsewhere check into the hospital with problems they are put in the normal pediatric ward which has no equipment for neonatal intensive care. Instead such high-risk newborns should be admitted to the neonatal intensive care ward just like newborns who are delivered at the hospital, so that they can avail of the necessary incubators and trained staff.

The Hospital San Juan de Dios has approached USAID for funding for training and salaries of their residents. Jayne Lyons is considering JHPIEGO training in family planning and obstetrics to complement the MotherCare assistance, plus Wellstart lactation management training.

We visited a typical rural health center, San Martin Sacatapaquez and saw the initial stages of TBA (comadrona) training being conducted by Dr. Carlos Gonzalez of INCAP which consisted of getting the TBAs, most of whom are illiterate, to draw pictures of what they perceive as dangerous when delivering babies in rural homes. Some comadronas mentioned the importance of having a scissors to cut the umbilical cord and candles for light. Many of them were very old, but there were young ones too. One of the biggest challenges to the INCAP/MotherCare effort to train the TBAs will be the fact that it is not a clean slate; most of the TBAs have undergone several training programs in the past and are set in their ways. A considerable amount of unlearning may be required which is always more difficult than learning something new. There may also be a language problem since Jayne Lyons suggested that many of the Mayan midwives do not speak Spanish, but the INCAP team only speaks and conducts the training in Spanish.

At a visit to the INCAP project office in Quetzaltenango it was encouraging to see that the office is set-up, staff are in place (including investigators for a vital events surveillance system), and the project is on track per the workplan. Studies are underway on maternal perinatal and neonatal mortality and reasons for acceptance or refusal of referrals by families. Barbara Schieber complained that too much of her time seems to be spent on administrative tasks; she travels down to INCAP headquarters in Guatemala City once a week which interferes with her work. She asked that MotherCare seek ways to reduce the amount of forms and report they require of her.

During the visit I also met Linda Hodge who is an intern paid by MotherCare to help with the Quetzaltenango Project. To date she had not found any discrete task that she could help with and appeared to be frustrated and feeling like a third wheel.

INCAP

The highlights of the discussions at INCAP, during which I was accompanied by Sandy Callier and Joe Koblens of ROCAP, follow. INCAP has three divisions: Nutrition and Health, Agriculture and Food Sciences, and Food and Nutrition Planning. Under the leadership of its new director, Dr. Hernan Delgado (since January 90), INCAP is drafting a strategic plan to redefine its role for the the 90s. The stress will be on science and technology, transfer of science and technology, and strategic management, but above all on becoming self-reliant as an institution. They are attempting to decentralize their work beyond Guatemala to the other member countries and each member country now has a basic technical group of 2-4 members to guide the INCAP work.

INCAP will resume its M.Sc. in nutrition training program in January 1992 in collaboration with San Carlos University, folding the former two separate courses in food science and maternal and child nutrition into one. Much training is now also done in the member countries. Distance education has been used effectively to teach courses in Guatemala to physicians and nurses on: (1) Protein-Energy Malnutrition Prevention and Treatment, and (2) Growth Monitoring. I suggested that they consider developing a distance education module on lactation management, possibly in collaboration with Wellstart. They have also developed audio-cassettes on breastfeeding and oral rehydration for patients to listen to in hospitals. The first teleconference will be held in late October on nutrition surveillance.

Maggie Fischer in the unit for Coordination of Information and Communication described a new breastfeeding project INCAP will begin in January 1991 with \$1.6 million in assistance from SIDA. The components will be: improving hospital practices, lactation management training, mass communication, support for working breastfeeding mothers and information dissemination. Dr. Delgado said that INCAP is very interested in doing more to promote breastfeeding and envisioned a particular role in lactation management training if INCAP could become a regional Wellstart. The Institute is also interested in collaborating with the APHA Clearinghouse on Maternal and Infant Nutrition in their work of regional information dissemination.

A computer software program developed by INCAP in collaboration with the Futures Group (RAPID-type), called SIMAP, which uses mapping to graphically display regions with the most severe nutritional problems has been very effective for convincing policymakers throughout the region of the need to tackle nutritional problems. I was not able

to view it but they described it as an excellent data for decision-making tool.

Teresa Gonzalez-Cossio has been studying the impact of supplementation with a high calorie cookie to 100 undernourished lactating mothers from 5 to 25 weeks postpartum on breastmilk volume, infant growth, maternal weight, etc. compared to a control group receiving a low calorie supplement. She found a maternal calf circumference of <30.4 cm to be the most predictive indicator of low birth weight and need for supplements (similar to findings of Eduardo Atalah in Chile). Her preliminary findings are that the average breastmilk output in both groups at the start of the study was 660 ml. However, when analyzed by quartiles of calf circumference there was a 100 ml difference in breastmilk output between the lowest and highest quartiles. The women who responded best to the supplement in terms of increased breastmilk output (850 ml at 20 weeks) were the moderately thin women (upper quartile), not the thinnest women (lower quartile). In the thinnest women the increased energy may have been used to replenish their own stores or for physical activity. The volume of breastmilk was affected but not the quality, or calories/ml. Few mothers exclusively breastfed; they didn't give cow's milk but instead gave coffee with roasted cereal and sugar or water with and without sugar.

Dr. Eric Boy has been working to identify the best screening criteria for predicting low birth weight and targetting programs in both Guatemala and Ecuador. So far calf circumference has been the most predictive anthropometric criteria. He is also developing pregnancy weight gain and uterine height reference standards for high altitude areas like Quetzaltenango (>2500 meters).

INCAP is testing doubly fortified sugar with both iron and vitamin A. Formerly only vitamin A was added. They also want to give iodized oil to pregnant women and vitamin A supplements to women of reproductive age. I warned of the danger (teratogenicity) of giving large doses of vitamin A to women who might be pregnant.

Dr. Boy discussed an ongoing trial in pregnant women of a new iron supplement, which is chelated with amino acids and made by Albion Laboratories, versus traditional ferrous sulfate. I mentioned that MotherCare is also interested in finding sites for testing a new delayed release HBS iron preparation in pregnant women. He expressed interest, so I gave him a protocol from the Jamaica trial, and a recent journal article and told him that staff from MotherCare would follow-up with him on their next visit to Guatemala to see if he is seriously interested.

Dr. Juan Rivera, Chief of the Nutrition and Health Division, described their collaboration in diarrheal disease research with WHO/CDD who has given INCAP funding for five studies. He also described the latest analysis of INCAP's longitudinal data set in which children who were supplemented 20 years ago are now 20 years of age. They are finding that adolescent girls and adult women who were supplemented in early childhood are significantly taller, have greater fat-free body mass, and greater work capacity than their malnourished peers who were not supplemented. Many more functional differences (in behavior, intellectual ability, etc.) between the supplemented and unsupplemented groups are detectable in adulthood than were observed in childhood. They plan to study birth weight of the next generation of those for whom they originally collected birth weights 20 years ago.

There has been clear deterioration in the nutritional status of children in the region in the face of economic crises, structural adjustment and political instability, even in Costa Rica. New entrants to primary school are shorter. INCAP gave me a useful report on nutritional status statistics for the region by country.

USAID

Jayne Lyons is the key contact in the Mission for maternal and neonatal health and nutrition activities. She is in the process of designing an FY 92 bilateral maternal and neonatal health project, which will expand the Quetzaltenango demonstration project to other parts of Guatemala using both public and private implementing agencies.

The Mission has made serious efforts to improve the PL480 MCH feeding program based on the findings of a January 1990 evaluation by DataPro, as described to me by Baudilio Lopez of the Human Resource Development Office. Targeting recipients by using objective nutritional status criteria for selection into and graduation from the feeding program is the biggest change. A participatory approach to planning these changes with all concerned PVOs has been very successful in getting the reforms accepted. Nutrition education will also be improved in the feeding programs through ongoing USAID supported work with DataPro in which INCAP is collaborating. There is an ongoing debate about growth monitoring between the MCH department of the MOH that wants to use traditional weight for age charts and the nutrition department which wants to use weight for height charts. Meanwhile there is a dearth of growth charts out in the field.

With reference to the Child Survival Project which has been frozen pending an investigation of use of funds by the

MOH, Lynn Gorton has been busy working on an options paper for the Mission Director.

ROCAP

ROCAP is busy preparing a PID for their continued support of INCAP once the current TRO project ends. They plan to establish an endowment to continue some support to INCAP but also to assist INCAP to become client-oriented and market its services so it can become self-sustaining. The PID is expected in AID/Washington in late November, and they were eager for INCAP supporters in Washington to advocate for approval. Beyond INCAP, the GDO Ann McDonald would like to see ROCAP get involved in population and AIDS work, but these have been sensitive topics.

FOLLOW-UP ACTIONS

1. Learn more about KMM project of Breastfeeding Commission. (Action: Taylor, MotherCare).
2. Follow-up on possibility of HBS iron trial with Eric Boy (Action: Taylor, MotherCare).
3. Confirm availability of Roberto Sosa for consultancy and advise Mission. (Action: Taylor, MotherCare).
4. Send information on breastfeeding and working women to Magda Fischer at INCAP. (Action: Anderson, AID).
5. Find way to reduce administrative and accounting workload of Barbara Schieber. (Action: MotherCare).

ANNEX I

ITINERARIO MARY ANN ANDERSON

Lunes 1 de octubre

9:00 Visita a APROFAM con Jayne Lyons

2:00 La Liga de la Leche
14 Calle 11-16, Zona 1
Teléfono 23696

Contacto: Marianne Stone de Jiménez

Martes 2 de octubre

9:00 Comisión para la Lactancia Materna
Ruta 4, 4-52S Zona 4, Edificio Maya
Teléfono 315128

Contacto: Dra. Ruth de Arango

4:00 Salida a Quetzaltenango
Punto de Reunión: AID
8a. Calle 7-86, Zona 9
Teléfono: 347628

Contacto: Jayne Lyons

Miércoles 3 de octubre

Quetzaltenango
Teléfono del INCAP 061-8245

Reservaciones hechas en Hotel Modelo
14 Avenida "A" 2-31, Zona 1
Teléfono 061-2529 ó 061-2715

Jueves 4 de octubre

9:00 ROCAP
2a. Calle 15-65, Zona 13
Teléfonos: 346761 al 3

Contacto: Sandy Callier

Se realizará una visita a INCAP con Sandy Callier.

Viernes 5 de octubre

Visita a San Vicente Buenabaj, Momostenango, Totonicapán
Salida: a las 6:00 aproximadamente pasarán a traerla al hotel
Casa Grande.

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ANNEX 2

List of Contacts

USAID/Guatemala
Office of Human Resource Development
8A Calle 7-86, Zona 9
Guatemala City, Guatemala
Tel: 347628

Jayne Lyons (Population)
Lynn Gorton (Health, Child Survival)
Baudilio Lopez (Nutrition)

ROCAP
General Development Office
2A Calle 15-65, Zona 13
Guatemala City, Guatemala
Tel: 346761

Ann McDonald
Sandra Callier
Joe Koblens

APROFAM (Asociacion Pro-Bienstar Familia de Guatemala)
9A Calle 0-57, Zona 1
Apartado 1004
Guatemala City, Guatemala
Tel: 537842

Dr. Roberto Santiso Galvez (Executive Director)
Dr. Jorge Solorzano

AGES (Asociacion Guatemalteca de Educacion Sexual)
3A Calle 3-59, Zona 1
Guatemala City, Guatemala
Tel: 26648-80949

La Leche League
14 Calle 11-16, Zona 1
Guatemala City, Guatemala
Tel: 23696

Maryanne Stone-Jimenez (Director)
Maria Lourdes de Ruano
Irma de Maya

Comision para la Lactancia Materna
Ruta 4, 4-52S, Zona 4, Edificio Maya
Guatemala City, Guatemala
Tel: 315128

Dr. Ruth de Arango (Technical Advisor)
Floridama Rivera (Coordinator)
Dina Nathusius (Founder and Advisor)

INCAP

Dr. Hernan Delgado (Director)
Lic. Magda Fischer
Lic. Teresa Gonzalez-Cossio
Dr. Eric Boy
Dr. Juan Rivera

INCAP/MotherCare Quetzaltenango Project

Dr. Barbara Schieber
Dr. Junio Robles
Dr. Carlos Gonzalez
Linda Hodge (intern)

Hospital San Juan de Dios, Quetzaltenango

Dr. Herberto (Obstetrics & Gynecology)
Dr. Mario Mejia (Neonatology)



ASOCIACION PRO-BIENESTAR DE LA FAMILIA DE GUATEMALA

— A P R O F A M —

Ficha Clínica de Pre y Post Natal

REGISTRO No.

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DATOS GENERALES:

NOMBRE: _____

EDAD: _____ ESTADO CIVIL: _____ OCUPACION: _____

DIRECCION: _____ TEL.: _____

ESPOSO: _____ OCUPACION: _____ EDAD: _____

LUGAR DONDE TRABAJA: _____ TEL.: _____

FECHA PRIMERA CONSULTA: _____ REFERIDA POR: _____

MOTIVO DE LA CONSULTA:

HISTORIA:

ANTECEDENTES:

MEDICOS:

Rubeola _____ Paludismo _____ Crisis convulsivas _____

Sarampión _____ Luas _____ Diabetes _____

Varicela _____ Gonorrea _____ Hipertensión _____

Hepatitis _____ Toxo _____ Infección Urinaria _____

Alergias _____

QUIRURGICOS:

Cesárea _____ Exploración _____ Hernioplastia _____

Legrado _____ Laparoscopia _____

TRAUMATICOS:

VACUNAS:

Polio _____ DPT _____ Viruela _____ BCG _____ Sarampión _____

ANTECEDENTES: FAMILIARES:

Diabetes _____ Gemelos _____
Enf. Cardiovasculares _____ Alcoholismo _____
Enf. Mentales _____ Anomalias Congénitas _____
Crisis Convulsivas _____ Otros _____
Madre _____ Padre _____
Esposo _____ VDRL _____ Grupo _____ Rh _____

ANTECEDENTES GINECO-OBSTETRICOS:

HISTORIA MENSTRUAL:

Menarquía _____ años; frecuencia _____ ; duración _____ ; cantidad _____
Dolor _____
G _____ P _____ AB _____ Fecha P.U.R. _____ Fecha U.R. _____
Parto probable _____

PARTO	TIPO	RN	PESO	FECHA	HOSPITAL	MEDICO
1er. parto						
2do. parto						
3er. parto						
4to. parto						
5to. parto						

EXAMEN FISICO:

Peso antes del embarazo _____ Lbs. Estado general _____
Temp. _____ Pulso _____ P.A. _____ Peso _____ Talla _____ Mts.
Mucosas Pan adiposo _____ Extremidades (várices) _____
Ojos _____ Nariz _____ Boca _____ Garganta _____ Cuello _____ Tórax _____ Piel _____
Ap. Respiratorio _____ Digestivo _____ Urinario _____

EXAMEN GINECOLOGICO

Abdomen _____ Mamas _____

Genitales externos: Labios mayores _____ Labios menores _____

Uretra _____ Cistocèle _____ Rectocele _____

Vagina _____ Periné _____

Cervix _____ Flujo _____

Cuerpo: Tamaño _____ Posición _____ Movilidad _____

Prolapso _____

Anexo derecho _____ Anexo izquierdo _____

Parametrios _____

EXAMEN OBSTETRICO:

Altura uterina _____ cms. Frecuencia cardíaca fetal _____ latidos/min.

Presentación _____

Posición _____

Variedad _____

Altitud _____ PELVIS _____

Semanas calculadas _____ Semanas estimadas _____

DIAGNOSTICO:

PLAN:

PROXIMA CITA:



Nombre _____

Reg. No. _____

Fecha probable parto _____

Fecha							
Apetito							
Náuseas, Vómitos							
Estreñimiento							
Cefaleas							
Trastornos Urinarios							
Visión							
Vértigos							
Disnea							
Dolores							
Hemorragia							
Flujo							
Movimientos							
Albuminaria							
Pulso							
Peso							
Presión Arterial							
A.U.C.U							
Presentación y Posición							
Altitud							
Foco							
Edemas							
Edad del Embarazo							
Otros							

OBSERVACIONES: _____

ANNEX 4

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Registro Hospitalario Número

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Fecha

HISTORIA CLINICA PERINATAL MINISTERIO DE SALUD PUBLICA DE GUATEMALA

Nombres: _____

Apellidos de soltera: _____

Apellido de casada: _____

Fecha de nacimiento: _____

Nombre de la Institución: _____ Código

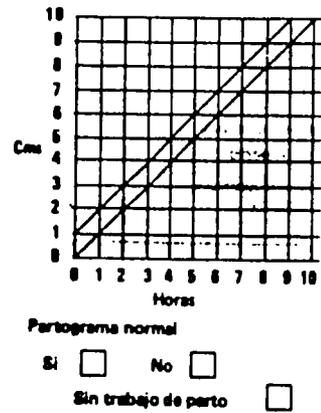
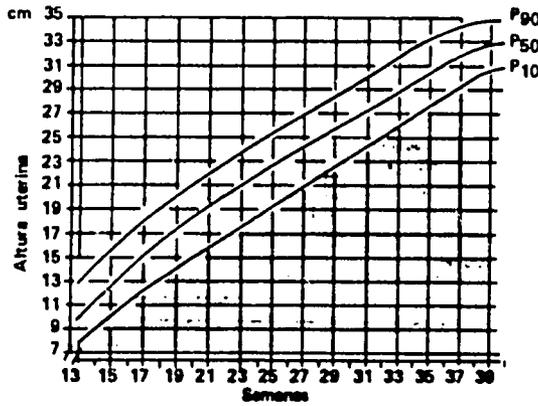
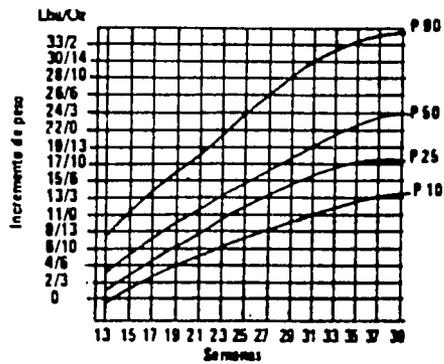
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Dirección: _____ Teléfono _____

Municipio: _____

Departamento: _____

IV. GRAFICAS



CODIGOS

PATOLOGIAS

- | | | |
|---------------------------|--|--|
| 00 Ninguna | 11 Anemia | 21 Infección de herida operatoria |
| 01 Embarazo múltiple | 12 DCP | 22 Infección pútrida |
| 02 Hipertensión crónica | 13 Hemorragia del primer trimestre | 23 Endometriosis |
| 03 Preclampsia | 14 Hemorragia del 2o. trimestre | 24 Choque séptico |
| 04 eclampsia | 15 Hemorragia del 3er. trimestre | 25 Infección urinaria |
| 05 Cardiopatía | 16 Amenaza de parto prematuro | 26 Hemorragia post parto |
| 06 Diabetes mellitus | 17 Trabajo de parto prematuro | 27 Lesiones |
| 07 Anemia crónica | 18 SFA | 28 Otras (especificar en espacio para observaciones) |
| 08 Parasitismo intestinal | 19 Embolia pulmonar | |
| 09 Embarazo ectópico | 20 Accidente de anestesia/complicaciones transop | |
| 10 RPM | | |

MEDICAMENTOS

- | |
|---------------------------|
| 0 Ninguno |
| 1 Analgésicos/anestésicos |
| 2 Anticoagulantes |
| 3 Betamiméticos |
| 4 Sedantes |
| 5 Hierro e vitaminas |
| 6 Esteroides |
| 7 Oxitocicos |
| 8 Antibióticos |
| 9 Otros |

V. TRABAJO DE PARTO

No. de examen	1	2	3	4	5	6
Fecha						
Hora						
P. A. (Max/Min)						
Num. contr./10 min						
Duración c/contrac (seg)						
Altitud (signo-num)						
Variedad de Pos						
FCF (lat/min.)						
Dilat Cerv. (cms)						
Meconio 1. Si 2. No 9 No corresp.						
CODIGO Patologías						
Medicamentos						
Observaciones						
Responsable						

VI. PARTO

Fuente principal de atención prenatal: Hospital <input type="checkbox"/> Medico particular <input type="checkbox"/> Centro/puesto de salud <input type="checkbox"/> Comadrona <input type="checkbox"/> Ninguna <input type="checkbox"/> Otro <input type="checkbox"/>	Número total de controles: <input type="text"/>	Número ingresos hospital en embarazo actual: <input type="text"/> Causas: <input type="text"/> (Ver código)	Terminación Natural (PES) <input type="checkbox"/> Forceps <input type="checkbox"/> Cesárea corp. <input type="checkbox"/> CSTP <input type="checkbox"/> Aborto <input type="checkbox"/> Otro <input type="checkbox"/>	Edad gestacional: <input type="text"/> Semanas AU <input type="checkbox"/> UR <input type="checkbox"/> USG <input type="checkbox"/> Método	Inicio del T. P.: Espontáneo <input type="checkbox"/> Inducido <input type="checkbox"/> No trabajo de parto <input type="checkbox"/>	Horas RPM: <input type="text"/>
Fecha de terminación: <input type="text"/> Hora <input type="text"/> <input type="text"/> Día <input type="text"/> <input type="text"/> Mes <input type="text"/> <input type="text"/> Año	Atendió parto: Médico <input type="checkbox"/> Enfermera <input type="checkbox"/> Estudiante <input type="checkbox"/> Comadrona <input type="checkbox"/> Empírico <input type="checkbox"/> Ninguno <input type="checkbox"/> Otro <input type="checkbox"/>	Lugar de parto: Hospital <input type="checkbox"/> Centro de Salud <input type="checkbox"/> Domicilio <input type="checkbox"/> Via pública <input type="checkbox"/> Casa de Salud <input type="checkbox"/> Otro <input type="checkbox"/>	Presentación: Cefálica <input type="checkbox"/> Pélvica <input type="checkbox"/> Hombro <input type="checkbox"/> Otra <input type="checkbox"/>	Indic. Forceps/Cesárea: SFA <input type="checkbox"/> DCP <input type="checkbox"/> Cesárea anterior <input type="checkbox"/> Toxemia <input type="checkbox"/> Hemo. 3er trim. <input type="checkbox"/>	Transversa <input type="checkbox"/> Podática <input type="checkbox"/> Agotamiento <input type="checkbox"/> Otro <input type="checkbox"/>	
Episiotomía: Si <input type="checkbox"/> No <input type="checkbox"/>	Alumbramiento: Natural/spontáneo <input type="checkbox"/> Artificial <input type="checkbox"/> Placenta completa: Si <input type="checkbox"/> No <input type="checkbox"/>	Desgarros: Piel y/o mucosa <input type="checkbox"/> Muscular <input type="checkbox"/> Rectal <input type="checkbox"/> Cervical <input type="checkbox"/> Uterino <input type="checkbox"/> Vaginal <input type="checkbox"/> Ninguno <input type="checkbox"/>	Anestesia/Analgesia: Local <input type="checkbox"/> General <input type="checkbox"/> Epidural <input type="checkbox"/> Pudenda <input type="checkbox"/> Narcóticos <input type="checkbox"/> Ninguna <input type="checkbox"/>	Cordón umbilical: Normal <input type="checkbox"/> Circulares <input type="checkbox"/> Brevedad <input type="checkbox"/> Nudo <input type="checkbox"/> Otro <input type="checkbox"/>	Líquido Amniótico: Normal <input type="checkbox"/> Meconio <input type="checkbox"/> Fétido <input type="checkbox"/> Oligo hidramnios <input type="checkbox"/> Polihidramnios <input type="checkbox"/> Otro <input type="checkbox"/>	

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VII. RECIEN NACIDO

ESTADO AL NACER		Sexo aparente: Masculino <input type="checkbox"/> Femenino <input type="checkbox"/>	Edad gestacional por examen físico: <input type="text"/> <input type="text"/> Semanas	Apgar <input type="checkbox"/> 1 minuto <input type="checkbox"/> 5 min.	Peso al nacer: Lb <input type="text"/> Oz <input type="text"/> Longitud <input type="text"/> <input type="text"/> cm	VDRL: Positivo <input type="checkbox"/> Negativo <input type="checkbox"/> Sin dato <input type="checkbox"/>	Edad alta/o al fallecer: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Días y Horas	Autopsia: Si <input type="checkbox"/> No <input type="checkbox"/> No corresponde <input type="checkbox"/>
Vivo <input type="checkbox"/> Muerte en embarazo <input type="checkbox"/> Muerte en parto <input type="checkbox"/> Muerte se desconoce momento <input type="checkbox"/>	Producto Simple <input type="checkbox"/> 1er. gemelo <input type="checkbox"/> 2o. gemelo <input type="checkbox"/>	Adecuación AEG <input type="checkbox"/> PEG <input type="checkbox"/> GEG <input type="checkbox"/>	Reanimación Si <input type="checkbox"/> No <input type="checkbox"/>	Circunferencia cefálica <input type="text"/> <input type="text"/> cm	Egreso RN: Sano <input type="checkbox"/> Enfermo <input type="checkbox"/> Traslado <input type="checkbox"/> Fallece <input type="checkbox"/>			

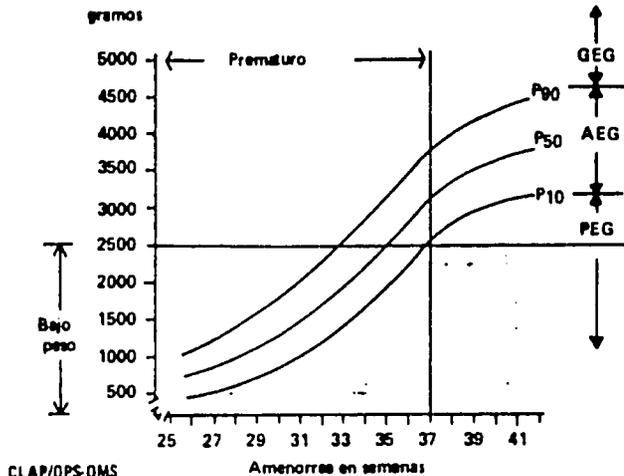
PATOLOGIA DEL RECIEN NACIDO

- Sano
- Memb. hialina
- Síndrome aspirativo
- Otro SDR
- Apnea
- Asfixia
- Hiperbilirrubinemia
- Síndrome icterico
- Hipoglucemia
- Neurológica
- Sepsis
- Hemorragia
- Trauma obstétrico
- Anomalia congenita
- Conjuntivitis neonatal
- Neumonía
- Meningitis
- Onfalitis
- Sífilis
- Enterocolitis necrozante
- Poliglobulia
- Otra

Observaciones:

RN atendido por:

- Pediatra
- Obstetra
- Enfermera
- Estudiante
- Otro



ADECUACION DE PESO PARA EOAD GESTACIONAL

VIII. PUERPERIO/EGRESO

Puerperio hospitalario	Primer control	Segundo	Estado al egreso	EGRESO DE LA MADRE	
Días Post parto o AB	<input type="text"/>	<input type="text"/>	<input type="text"/>	Sana <input type="checkbox"/>	Plan educacional: Si <input type="checkbox"/> No <input type="checkbox"/>
Temperatura	<input type="text"/>	<input type="text"/>	<input type="text"/>	Enferma y estable con tratamiento <input type="checkbox"/>	Lactancia materna <input type="checkbox"/>
Pulso	<input type="text"/>	<input type="text"/>	<input type="text"/>	Egreso contraindicado <input type="checkbox"/>	Higiene personal <input type="checkbox"/>
P. A. (Max - Min.)	<input type="text"/>	<input type="text"/>	<input type="text"/>	Traslado <input type="checkbox"/>	Anticonceptivos <input type="checkbox"/>
Invol. Ut. 1. Normal 2. Anormal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fallece en embarazo <input type="checkbox"/>	
Loquios 1. Normal 2. Anormal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fallece en parto <input type="checkbox"/>	
CODIGO Patologías	<input type="text"/>	<input type="text"/>	<input type="text"/>	Fallece en puerperio <input type="checkbox"/>	
Medicamentos	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Lactancia: Materna <input type="checkbox"/>				PUERPERIO TARDIO	Lactancia Solo materna <input type="checkbox"/>
Mixta <input type="checkbox"/>				Días post parto <input type="text"/>	Mixta <input type="checkbox"/>
Otra <input type="checkbox"/>				Examen normal: Si <input type="checkbox"/> No <input type="checkbox"/>	Artificial <input type="checkbox"/>
				Patología <input type="text"/>	Lactante vivo Si <input type="checkbox"/> No <input type="checkbox"/>
				Conducta <input type="text"/>	
				Alta <input type="checkbox"/> Reconsulta o referencia <input type="checkbox"/> Ingreso <input type="checkbox"/>	