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THE TRAINING AND PRACTICE
OF
TRADITIONAL BIRTH ATTENDANTS
IN GUATEMALA

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EXECUTIVE SUMMARY

BACKGROUND

At the request of USAID/Guatemala, two PRITECH consultants, Pamela Putney and Barry Smith, made an in-depth study of the midwifery practices of traditional birth attendants of the Guatemalan highlands with a view towards making recommendations as to how midwifery practice could best be supported or modified to enable it to make a maximum contribution to maternal and child health. The two consultants reviewed over 100 documents, interviewed government, donor and non-governmental organization (NGO) personnel, visited field sites of both public and private programs and conducted an informal seminar to discuss recommendations with the participation of various donor, NGO and governmental institutional representatives.

Recent health surveys indicate that while Guatemala has made important strides in reducing infant and child mortality, it continues to have some of the worst health statistics in the continent. The infant mortality rate (IMR) has dropped from over 90 deaths per 1000 live births fifteen years ago to approximately 70 at present. These statistics, however, hide regional differences. In the rural highlands the IMR is 120 or higher. Currently 31% of all infant deaths occur within the first 28 days of life, those are deaths that studies show can be reduced through improved prenatal, delivery and postnatal care. In regards to maternal mortality, the WHO estimates that the lifetime risk of a woman in a developing country dying in pregnancy or a pregnancy-related illness is around 1 in 40 contrasting sharply with the 1 in a thousand or thousands risk for women in the developed world. Among the highland's Mayan population over 80% of all births are attended by midwives. Given the GOG's estimate that its obstetrical capacity is 20% of all births, it can rightly be assumed that the midwife is, and will continue to be, the key element in any efforts to reduce infant and maternal mortality.

The historical role of the Mayan midwife in Guatemala has both supernatural and practical aspects. The midwife traditionally had a very high status in her community partly by virtue of her selection by God through dreams and signs as a midwife. The midwife performed abdominal massages, manipulating the position of the fetus as necessary to achieve a head first presentation, made dietary recommendations, prescribed herbal remedies as needed and promoted the use of the sweatbath. During labor the traditional birth attendant's role was largely supportive, delivery was attended in a squatting or kneeling position and the cord was cut after delivery of the placenta, usually with a red hot cutting instrument or simply burned with a candle. Postnatal duties included a ceremonial sweatbath and meal between 8 and 40 days after the birth.

The GOG introduced TBA licensing regulations in 1935 and began training programs as early as 1955. UNICEF, CARE, UNFPA and AID have all supported training at some time. The current MOH training program is for 15 consecutive days, eight hours per day and covers nine subject areas, is regulated by the norms of the MOH's Maternal and

Child Health Division, is planned by the Area staff and largely conducted by the district nurse with the assistance of the auxiliary nurses.

CURRENT TBA PRACTICE

Current TBA practices are centered around the prenatal, delivery and postnatal period. The principal prenatal practices are abdominal massage and external version (this practice is actively discouraged in the MOH training program), dietary counselling revolving around the appropriate use of "hot" and "cold" foods, the performance of rituals to assure a safe birth and, increasingly, referral of the mother to the health center for prenatal medical exams and tetanus toxoid immunization. There is a wide variation in the number of deliveries per TBA per year, varying from a few to over one hundred. The midwife provides emotional support, abdominal massage and herbal teas to relieve the discomforts of labor. Once perineal pressure is felt by the mother, the TBA encourages her to push. An increasing number of TBAs are using injectable oxytocins (hormonal uterine stimulants) to hasten the process of labor. Birth normally takes place at the mother's home with husband and married female relatives present. Lights are quite low and the mother does not remove her skirt, respecting the traditional modesty of the Mayan women. The preferred position for delivery continues to be squatting or on the knees, despite having been taught otherwise in their training courses. The baby is received by the midwife in a clean cloth and set to the side until the placenta is delivered. Once the placenta is delivered the TBA cuts the umbilical cord with scissors (often reading augers about the life of the child and numbers of babies of the mother from the cord and placenta). The scissors are often not properly sterilized. Many midwives continue to cauterize the cord with a candle, although this practice is discouraged by the training programs. Once the cord is cut the baby is washed and swaddled and generally put to the breast. After delivery the abdomen is bound. The TBA makes several postnatal visits, massaging the uterus and often participates in a ritual sweat bath and meal at the end of the period of convalescence.

There are estimated to be approximately 20,000 TBAs in Guatemala around 70% of which are trained. Although the report does not examine the practice of midwifery among the ladino population, previous studies have shown that in contrast to the Mayan population, the ladino population prefers hospital delivery and the ladina midwife is held in a position of less regard than her Mayan counterpart. Despite anecdotal information to the contrary, the authors could not find any confirmation of the impression that TBAs treat illnesses not related to pregnancy. Most TBAs receive payment for their services in cash or kind. Average payments vary from 3 to 20 Quetzales. Among the Mayan population, supernatural recruitment to the midwifery profession continues to be common. Most midwives have attended several births prior to attending the training course. Untrained TBAs are identified through contacts with mothers in the health clinic and through the review of municipal records. Midwives are invited by the MOH to training courses depending upon funds available. Each midwife receives a stipend of Q75 for the 15 days of the course. In addition, each midwife is supposed to receive a UNICEF Midwifery Kit, which currently only contains scissors, two yards of muslin cloth and a kilogram scale.

One of the most important and difficult areas addressed in the report is in regard to the effectiveness of midwives and of their training programs. The only data available is that collected by the University Francisco Marroquin in one municipality. That data, however, provides evidence that midwife training makes an impact not only on TBA practices, but also on mortality rates.

The pivot around which an effective midwife programs revolves is the identification, referral and proper institutional management of high risk pregnancies. Serious cultural, geographic, linguistic, economic and emotional barriers to referral exist.

In addition to the Ministry of Health, a number of non-governmental and international organizations support TBA training activities. The Association of Community Health Services (ASECSA) no longer carries out TBA training, however ASECSA has published one of the better TBA manuals. In the Project Concern International Project in Santiago Atitlan, the TBA training plays an important role, as it does with Clinica Maxena in Santo Tomas la Union, Suchitepequez. The use of indigenous professionals and promoters for training and supervision distinguishes these programs. Project HOPE has long included TBA training and supervision in its Child Survival initiative in Quetzaltenango and San Marcos. The Maryknoll Mission Hospital in Jacaltenango, Huehuetenango will be the site of a UNICEF funded initiative to better understand the beliefs and practices which underlie traditional practices and thereby permit the development of training programs which build upon, rather than destroy, those practices. The Medical School of the Francisco Marroquin University has one of the most effective and best studied TBA programs. All of the information on effectiveness in this report came from the excellent information system of that program. INCAP has several research efforts underway. The most far reaching is that being carried out in Quetzaltenango, which will be the most comprehensive and organized look at TBA and institutional practices in regards to the management of high risk pregnancies. Donors, including UNICEF, UNFPA and AID work mostly through the Ministry of Health, although they have also provided funds to some NGO's. There has, however, been practically no interagency cooperation.

ANALYSIS OF TBA PRACTICE

The authors believe that it has been inappropriate and damaging to have tried to unquestioningly apply a western, urban, hospital based birthing model to TBA training. An additional problem identified is the gap between stated training goals and the capacity of the MOH to reach those goals. Limitations include budgetary restrictions, inadequate referral system and poor interpersonal relations between some MOH professionals and both the TBA and the community. The authors believe that the current 15 day training course is too didactic, too complex and too dry for this largely illiterate population of mostly older, rural women. Another training constraint is that many of the TBAs have more experience than the nurses teaching them, certainly with regard to home birth experience. This undermines the trainers' credibility and certainly

decreases their confidence in approaching the subject matter in a creative, informal and spontaneous fashion.

Training content is analyzed in regard to its impact on TBA practice. The great reduction in both the use of alcohol by TBAs and their laboring patients and in the practice of having the women push too early in labor are two of the harmful traditional practices on which training courses have had a positive impact. Several beneficial new practices have been introduced through training programs including hand washing, high risk screening and referral, nutrition counselling, prenatal referral for tetanus toxoid vaccination and improved attention to the newborn. Unfortunately, three positive traditional practices have been vigorously discouraged by trainers: the upright delivery position, external version in the case of malpresentation of the fetus and cauterization of the cord. Several "neutral" or somewhat beneficial practices are discussed and often discouraged in training programs. These include the use of the traditional sweat bath ("temascal"), use of medicinal herbs, prenatal and postpartum massages and uterine binding. The new and widespread practice of giving intramuscular injections of hormonal uterine stimulants (oxytocics) is very disturbing and preliminary evidence suggests that it is responsible for a significant increase in intrauterine fetal death. Finally, both the use of TBA kits such as that provided by UNICEF and the definition of what should constitute a high risk pregnancy requiring referral are discussed.

OBSERVATIONS

The principal observations are the following:

1. Despite the fact that the TBA is the major provider of health care for women in Guatemala and has the greatest potential to impact on perinatal and neonatal mortality, she receives little recognition or support for her contribution to the health care system in Guatemala.
2. Inadequate attention has been paid to the training of effective trainers of TBAs. In general, the training courses do not use innovative, effective and appropriate educational materials. Much of the training content is ethnocentric, institutional based, inaccurate and inappropriate for childbirth in the community.
3. There has been a lack of both investigation and evaluation of actual TBA practices, their impact on maternal/infant mortality and the impact TBA training has had on improving MCH outcomes.
4. There are several exciting and innovative programs underway in Guatemala. One is the TBA/MOH high risk pregnancy management study being conducted by INCAP in Quetzaltenango. A second is the soon to be initiated ethnographic investigation to be carried out by the Maryknoll Mission and the MOH in Huehuetenango, funded by UNICEF. Another is the Francisco Marroquin University project in San Juan Sacatepequez.

RECOMMENDATIONS

Given the lack of response to previous evaluations of the situation regarding TBAs in Guatemala, it is recommended that USAID and other donors give as much attention to the process of change as to the content. In that regard the consultants recommend the holding of an expert seminar/workshop on TBAs to address such questions as appropriate village level practices with a careful, scientific literature search to help in guiding discussions, a look at training methodologies, a look at management systems such as supervision, monitoring and evaluation and a look at donor coordination.

For the purposes of discussion, we have divided the additional recommendations into 6 target areas: Institutional Development, Training, Health Education, Inter-Agency Coordination, Research/Evaluation and Other.

A. INSTITUTIONAL DEVELOPMENT

1. A training course in working with the community should be developed and incorporated into the pre-service training programs for all physicians and nurses. Course content should include role of the TBA in Guatemala, inculcation of respect for cultural differences, community outreach, communication and supervision skills, awareness that Western medicine is one of many, but not necessarily the only or the best, health system and practical experience with the TBAs.
2. An in-service education program in working with TBAs should be developed and conducted for all MOH personnel, using the guidelines outlined in recommendation #1.
3. Mechanisms to improve the supervision and monitoring of both TBA practice and training impact on practices need to be developed and implemented.
4. The impact of TBA referral on reducing maternal/infant mortality depends on the appropriateness of the treatment of high risk cases by the health care system. Recommendations for improving the high risk referral system include improved monitoring of MOH response to TBA referral, redefinition of high risk priorities and the development of high risk case management review committees.

B. TRAINING

1. TBAs themselves should be responsible for conducting as much of the training as possible, in collaboration with health personnel.

2. The TBA training course content should be re-evaluated and revised. This should include a literature review of "safe" obstetrical practices, reduction and prioritization of content, adaptation of content to the home setting and the elimination of abstract content.
3. The length and timing of the TBA training course should be modified. The training would probably be significantly more effective if it were given in a series of shorter (eg; 1-5 days), regular sessions over a period of time (eg; 6 mos. to 1 year).
4. The MOH TBA Training Manual for both trainers and TBAs should be revised. The revision of the manual should include, among other things, drawings of mothers giving birth in upright positions. Field testing and validation of the redesigned manual should be carried out prior to publishing it.
5. Effective, in-expensive, locally made tools and materials for TBA training (eg; models for demonstration, large culturally appropriate flip charts) should be developed.
6. An in-service training program to train trainers of TBAs should be developed and given to all health personnel involved in TBA training.

C. HEALTH EDUCATION

1. Program efforts to educate families in the community on safe birthing practices, the dangers of using IM oxytocin, the health benefits of prenatal care and child survival interventions (eg; immunizations, ORT) should be expanded. This could be accomplished by targeting areas served by health posts using community health workers/volunteers, church groups, mothers groups, medical and nursing staff/students. Health education activities could be coordinated and expanded through the PVOs.
2. The feasibility of using social marketing (eg; HealthCom) to promote education in the areas mentioned above should be evaluated.

D. INTER-AGENCY COORDINATION

1. Efforts should be made to improve inter-agency coordination in the development and implementation of TBA initiatives.
2. The formation of a national midwife association should be explored.
3. USAID should consider supporting the creation of a national PVO which would be responsible for the coordination of TBA activities.

E. RESEARCH/EVALUATION

1. The lack of any evaluation on the effectiveness and impact of TBA training has been a major gap. Evaluation and monitoring of TBA training and supervision should be an integral part of any future training activities.
2. Increased research should be supported in the following areas:
 - TBA practices in the community and their relationship to maternal/infant mortality and morbidity.
 - The major causes of maternal/infant mortality and morbidity in Guatemala, with an emphasis on the neonatal and perinatal periods.
 - The relationship of prenatal care to improved outcomes (what specific prenatal interventions and why).
 - The impact of TBA training on changes in practice and maternal/infant mortality and morbidity.
 - An evaluation of the standard protocols and medical management of high risk cases.
3. USAID should consider increased support for Dr. Barbara Schieber's project in Quetzaltenango and a follow-on project to Dr. Al Bartlett's study. These projects have the potential to impact significantly on the reduction of maternal/infant mortality and morbidity in Guatemala.
4. Further investigation of TBA practices in the Ladino community should be considered.

E. OTHER

1. The UNICEF delivery kits should be replaced with a locally made alternative. This is discussed in depth in section 5 f. of the document.
2. Methods for stopping the sale of IM oxytocin in pharmacies should be explored on both the local and national level. The sale of this drug appears to be increasing and its inappropriate use constitutes a grave danger to the health of mothers and infants in Guatemala.

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THE TRAINING AND PRACTICE OF TRADITIONAL BIRTH ATTENDANTS IN GUATEMALA

I. BACKGROUND

A. Summary of Scope of Work

A copy of the official Scope of Work can be found in Appendix A. In the initial discussions with USAID staff, the consultants were directed to focus on TBAs, with a special emphasis on TBAs in the Mayan populations where the majority of maternal/infant morbidity and mortality occurs. Specifically, the consultants were asked to describe in detail the practice of midwifery in the community and the training and relationships of TBAs with the formal health care system. Using available information, it was requested that an assessment be made of the effectiveness of training programs in reducing TBA practices which are believed to contribute to maternal/infant morbidity and mortality. Based on the above, conclusions and recommendations were to be developed to increase the effectiveness of existing training programs and to identify the potential and the feasibility of an expanded role for TBAs in the provision of Child Survival interventions in Guatemala.

B. Methodology

The methodology used by the consultants in the preparation of this report was based on document reviews, interviews, field visits and the review of an informal working group of experts involved in TBA activities.

Documents were identified by consultants, by the PRITECH Resource Center and by Guatemalan sources prior to the arrival of the consultants. Additional documents were identified in the course of interviews. Over 75 documents were reviewed of which approximately 50 were deemed relevant and are included in the Bibliography (see Annex D).

Interviews were conducted with all public and private institutions with experience in working with TBA's of which the consultants had knowledge. Interviews were conducted at both the central and field level. (See Annex B for schedule and list of contacts.)

After the preparation of the initial draft, recommendations were discussed by a multidisciplinary group of persons experienced in TBA training in Guatemala. This document includes the comments and observations of that group.

C. Relevant Mortality, Morbidity and Demographic Data

The Government of Guatemala with the support of international agencies such as UNICEF, PAHO and AID began a major initiative to reduce infant and childhood mortality and morbidity in the mid-1980's. Although Guatemala occupies one of the worst positions in the hemisphere in regards to health indicators, there has been a notable decline in overall infant mortality (IMR) from an estimated 92.4 deaths per 1000 live births in the 1972-1974 period to an estimated 73.4 in the 1982-1987 period (1987 Demographic and Health Survey). According to the recently completed Demographic and Health Survey (DHS) the IMR is higher in rural areas (84.5 vs. 65.3) and in the central highlands (119.3). Of all infant mortality, 31% is neonatal mortality (Bossert and Del Cid, 1987). National data on the leading causes of neonatal mortality (deaths within the first month of life) are not available, but studies done in Santa Maria Cauque as well as current work being done by Dr. Al Bartlett of INCAP and Dr. Carlos Andrade of Francisco Marroquin University, suggest that the leading causes of neonatal mortality are asphyxia and birth trauma, prematurity/low birth weight, sepsis, respiratory infection and tetanus in some areas (Bartlett, personal communication). Data from 1988 from the municipality of San Juan, Sacatepequez collected by Francisco Marroquin University medical school staff show the following in terms of neonatal morbidity: sepsis 17%, diarrhea and sepsis 14%, perinatal asphyxia 12%, hyperbilirubinemia 8%, bronchopneumonia 4% and neonatal tetanus 4%. The five cases of neonatal deaths in 1988 from the same municipality were from tetanus, septic diarrhea, cardiac arrest, hyaline membrane disease and sepsis (Andrade, 1988) Low birth weight, a leading contributor to many of the above, occurs in 18% of all births. Official statistics show 20 stillbirths occur for every 1000 live births (MOH, Norms and Guidelines for Maternal Child Health) but careful studies done in other parts of the country suggest that it may be as high as 40. If the definition of infant mortality were expanded to include perinatal mortality (death from 28 weeks of gestation to age seven days) then close to 50% of all infant mortality would occur before the age of one month.

In regard to maternal mortality, Guatemala has a reported maternal mortality rate of 144 maternal deaths per 100,000 live births (Ibid.), although World Bank data place it at almost ten times higher (1000 to 17000 deaths per 100,000 live births). While the World Bank figure is probably inflated, considerable under reporting probably affects the official figure since there is very little incentive to report the death of a mother who dies in the home from a pregnancy related complication. The WHO estimates the average Latin American maternal mortality rate at nearly 300/100,000 (Population Reports, September, 1988) and since Guatemala falls below the Latin American average in other health indicators it would be expected to do so in maternal mortality as well. As a basis for comparison, the maternal mortality rate in the United States is 8/100,000. According to MOH statistics 86% of maternal deaths are due to "Direct Obstetrical causes" with abortion and hemorrhage being the second and third leading causes. In its MCH norms, the MOH states that the principal causes of maternal morbi-mortality are abortion, hemorrhage, postpartum complication and toxemia of pregnancy. In general the leading causes of maternal deaths throughout the world are hemorrhage, infection, toxemia, abortion and obstructed labor. Three of the five leading causes of all hospital discharges in Guatemala are pregnancy related (normal birth 24%, direct obstetrical

causes 8% and abortion 5%) (Bossert and Del Cid, 1987) indicating the tremendous importance of pregnancy related activities to the formal health system.

In Guatemala at least 60% of all births are attended by TBAs. This rises to almost 70% in the rural areas and to almost 80% in the rural Mayan areas (DHS), the main focus of this report and the area where infant and maternal mortality rates are the highest. In some areas over 90% of all deliveries are attended by TBAs. Western trained professionals only attend 10% of Mayan births and less than 30% overall in the country. The MOH has stated that its current capacity does not permit it to attend much over 20% of births and that this situation will remain unchanged for the foreseeable future. The TBAs also provide over one-half of all prenatal care to the Mayan population.

D. Historical Role and Place of the TBA

Among Mayan communities in Guatemala, the TBA has traditionally held a place of high status in the community as a "ritual specialist" (Paul and Paul, 1975). Her role as a TBA was seen as being divinely mandated through signs from God including being covered with a veil (amniotic membranes) at birth, dreams teaching her how to attend births, the finding of strangely shaped objects in her path and the suffering of serious and prolonged illness until she arose to accept her responsibilities as a TBA. The TBA was almost invariably married and a mother. Her role as a TBA involved breaking a number of traditional taboos on female behavior including traveling alone and often at night, touching normally "unclean" things at the time of birth such as female genitalia, blood and the afterbirth, relegating household responsibilities to a secondary importance and, in some areas, observing sexual abstinence before and after a delivery.

The TBA was normally consulted early in the first pregnancy and often not until the last trimester in later pregnancies. The initial request was formal and ritualized and included the presentation of gifts, food or drink and an act of deference to the TBA. Her prenatal attentions were directed towards massaging the abdomen, often with heated oils for the purpose of determining and, if necessary, adjusting the position of the fetus, gradually "detaching" the fetus from the uterus so that the delivery would be less painful, to ease delivery, to maintain the uterus "in place" and to make the fetus more comfortable (Cosminsky, 1977). The TBA frequently prescribed herbal remedies and dietary restrictions. These restrictions were oriented towards prohibiting "cold" foods which could damage the "hot" condition of the pregnant women. Pregnancy was considered a state of physical and spiritual weakness. The use of the "temascal" (sweat baths) was also quite common during the prenatal period, but is being abandoned in more recent times (Ibid.). As a ritual specialist, the midwife frequently observed rituals and said prayers for a safe labor.

During labor the midwife played a supportive role, often providing herbal teas to strengthen labor and massages to ease discomfort. Most TBAs encouraged the mother to push from the beginning of labor often resulting in fatigue. If the fetus was discovered to be transverse, attempts were made during labor to adjust the position. The mother usually delivered in a squatting, kneeling or sitting position, with the

assistance of the husband and presence of married female relatives. The action of the TBA was principally to receive the child. Once delivered, the TBA's attention was focused on the delivery of the placenta. The cord, usually severed with a hot blade, was not cut until the placenta was delivered for fear that the placenta would rise within the mother and choke her. Massages, teas, abdominal binders, provoking vomiting by putting hair or similar items in the throat and various changes in position were utilized to hasten delivery of a retained placenta. The TBAs did not apparently provide much attention to the newborn until after delivery of the placenta. Once delivered, the baby was washed in warm water and wrapped in warm clothing. In some areas the infant was given directly to the mother for feeding, while in other areas colostrum was not considered good for the child, so sweetened waters were given or other nursing mothers were found to feed the baby until the mother's milk came in.

Postpartum attention included postnatal massage, application of abdominal binders, the preparation of meals, cleaning of the parturient's house, occasional postpartum visits to the women and often the performance of a ritual bath in the temascal at the eighth day. Once the ritual bath was performed with attendant ceremonies, the midwife's responsibilities were considered completed.

E. History of TBA Training and Licensing Programs in Guatemala

Since 1935 the Government of Guatemala has attempted to regulate traditional midwifery and link it with training through a licensing program. Articles 98 and 99 of the Governmental Decree of April 16, 1935 delegate to the General Directorate of Health Services the responsibility of granting permits to midwives through an examination procedure. It also states that any midwife who is summoned to attend a training course and does not do so is prohibited from delivering babies.

What, if any, organized training activities were sponsored by the Government for the next twenty years is not known. Section F, Article 15 of Decree No. 74 dated May 9, 1955 empowers the Ministry of Health to "extend certification of authorization to traditional midwives after an aptitude test." Early anthropological studies (Cosminsky, 1977) suggest midwives believed "they might be jailed or fined for practicing without a license if they did not attend", but also that "the acquisition of Western medical training and a license raises one's status, especially if this is added to one's supernatural validation." Annual medical exams were required for relicensing. The same source states that the course consisted of classes twice per month for over a year with expenses absorbed by the midwife. Courses were probably given mostly in the departmental capitals. Cosminsky, quoting one TBA's perception of the content of the program, states:

"They were instructed to wash their hands, use clean white cloths, disinfect the cutting scissors, calculate delivery time, not to have the mother push too early, use the supine or horizontal delivery position instead of the traditional kneeling one, not to use herbs, cut the cord before the placenta is expelled, use alcohol on the cord instead of cauterizing it, not to use postnatal

sweatbaths, and to have the mother eat a balanced diet. ... The midwives were also instructed to refer any possible complications, such as transverse births, breech presentations, multiple births, delayed deliveries, retained placenta and hemorrhaging to the nearest doctor or hospital, instead of trying to handle it themselves."

With the creation of the Maternal Child Health Division of the Ministry of Health in 1969, greater impetus and focus was given to the midwife training program. As of 1975, 6,000 midwives had been trained, of which only 905 maintained a relationship with the local health services (Harrison, 1977), reflecting the deficient supervision system. Officials estimated another 10,000 untrained midwives were practicing and delivering two-thirds of all midwife attended births. UNICEF and AID appear to have been the principal funding sources for training during this period.

In 1980 the MOH, with technical assistance from PAHO, revised its TBA training manual and produced the manual which is currently being used. That manual is directed to the professional nurse trainer and no manual for the TBA is utilized. The manual is currently undergoing a reanalysis with INCAP assistance. In the early 1980's two other training manuals for both trainers and TBAs were developed. One was developed as part of the AID financed Integrated Community Health and Nutrition Systems Project being implemented in three western departments. Well illustrated manuals were used around which training activities were supposed to focus. Courses were given for five days per month for three months with a one day reinforcement session afterwards. Principal responsibility for training was put into the hands of the auxiliary nurse. The lack of political support for this effort within the MOH limited its impact and those manuals are now only of historical interest. At about the same time the INCAP SINAPS project was developing another set of training manuals. Those manuals have also fallen into disuse.

During the early 1980's the MCH Division achieved the incorporation of some national funds for TBA training into the MOH budget, thereby lessening its total dependence on external funding. Unfortunately, in 1983 that line item was eliminated and later that same year the MCH Division was dissolved resulting in a suspension of TBA training activities. Late in 1984 the Division was reestablished and in 1987 some 2093 midwives were trained. At that time CARE, UNICEF and UNFPA were all financing TBA training activities. The current program is based on the fourth edition of the "Manual for the Tradition Birth Attendant Training Team", dated December, 1980. The training occurs for fifteen consecutive days and no manual is given to the TBAs. The principal responsibility for the training is in the hands of the professional nurse, not the auxiliary. The current training program is discussed in greater detail below.

II. CURRENT SITUATION

A. TBA Practice and Role in Recent Years

1. Current Practice of Midwifery in the Community

The following section attempts to describe in a concise fashion current TBA practices among the Mayan population. The importance, however, of understanding these practices in the context of the belief system which many of them represent cannot be overemphasized. INCAP investigators working in the Quetzaltenango area, for instance, have noted that the concept of "risk" as understood by western educated professionals does not exist among the Mayan midwives and, therefore, creative approaches to teaching referral of "high risk" pregnancies must be found. The Mayan belief system will be touched upon occasionally in the following discussion but the anthropological literature should be consulted for a more complete understanding.

a. Prenatal Practices

Abdominal Massage and External Version

The performance of abdominal massage as described above during the various prenatal visits continues to be one of the most ubiquitous and uniform TBA practices. The visits and massages are characteristically at monthly intervals initially and increase in frequency as the projected date of delivery approaches. The practice of external versions which was considered naturally within the midwives' purview is still practiced, but is probably going underground and gradually being lost due to insistence in training programs that it is dangerous and should not be practiced by the midwives. Taking place as it does in the home of the mother, the massage also provides an opportunity for the development of intimacy and trust between the mother and the midwife.

Diet

The TBA continues to provide the expectant mother with dietary information. The hot or cold nature of foods continues to be important to both the patient and the mother as described above. This often brings local beliefs into conflict with the advice given in the TBA training courses which promote the eating of certain "cold" foods such as beans and eggs. The midwife also advises the mother to satisfy whatever food craving she may have, otherwise the child will be harmed.

Rituals

The authors were not able to affirm whether or not the customary rituals continue to be an important part of the midwives services, but it is expected that this aspect is declining with the continued encroachment of Western practices and culture.

Referral

As a result of MOH training programs, TBAs are increasingly referring their patients to the MOH for tetanus toxoid injections and for medical prenatal checks. As of 1987, however, only 14% of mothers having babies in the previous five years had received tetanus toxoid and, in the Mayan areas, only 16% had gone to a health center for prenatal care.

b.Labor and Delivery

Number of Deliveries Per TBA

The number of deliveries per TBA varies widely. Often in a single community with four or five midwives the oldest and most experienced will attend 60% or 70% of the births, the second most experienced will have 20 to 30% and the others will have what is left over. In the section on midwives in the 1977 Health Sector Assessment, Dr. Polly Harrison quotes rates in Guatemala from a maximum of 121 per year to as low as four. In the field visits one of the busiest midwives claimed to deliver 20 to 30 babies per month while others, particularly those just starting, had two or three. In the study of traditional midwives carried out by the Ministry of Health in Honduras 45% of the midwives attended four or fewer births, 25% from five to eight births per year and 30% nine or more. A similar distribution is probably characteristic of Guatemala as well.

Assessment of Labor

The midwife is called when labor begins. Most midwives query the mother as to the frequency, duration and strength of the contractions. A few midwives do an occasional vaginal exam, not so much to determine degree of cervical dilatation, but more to evaluate degree of descent of the fetus and to help them decide whether the moment has come to instruct the mother to push. If, upon initial exam, the TBA decides that the moment of delivery is far off, she will often go home and return several hours later. It was not infrequent during our interviews with the midwives to be told stories about midwives who were summoned to attend another midwife's patient because the other midwife was off attending some other birth, had left because she thought the delivery was still a long way off or simply did not arrive in time. In the Honduras midwife study, in about one fifth of the cases the midwife arrived after the delivery of the baby.

Management of Labor

A variety of techniques have been developed to assist the mother with labor. The most common is abdominal massage. Discussions with the TBAs suggest that there are many, especially those from the most remote communities, who will continue to attempt the correction of malpresentation at the time of labor (especially a transverse lie). In many communities the ingestion of alcohol by both the mother and the midwife continues to be common. Some midwives prescribe herbal teas or other light foods like soups to be taken during the initial stage of labor to give the mother strength, and in the case of

teas, to reduce the discomfort. The practice of having the mother push from the very beginning of labor seems to be disappearing, largely as the result of training efforts. The mother is encouraged to sit up or walk around as long as she is able.

A very distressing practice which is not mentioned in any of the literature but is increasingly widespread is the use of oxytocin to hasten labor. The investigators found this practice in all of the highland departments visited and the drug is widely available in pharmacies throughout the country. The consultants were easily able to purchase IM oxytocin in local pharmacies (cost approximately Q2 for a 5 I.U. vial). On one visit to a TBA's home, the consultants observed 10 vials of IM oxytocin lying on a table, surrounded by used needles and syringes. The TBAs all know that the MOH condemns this practice but they say that the mothers or mothers-in-law insist on using it and when the TBA refuses to give it, the family hires a pharmacist or an "inyeccionista" to do it. There is no uniformity in regards to the proper indications for its usage or proper dosage. Some TBAs say they give it when the child is crowning, others early in labor and one TBA proudly stated she recently gave four injections at five minute intervals during an obstructed labor.

Environment

To a certain extent, birthing is a social event in the Guatemalan highlands with husband, mother-in-law and married female relatives often present. The husband's role is the most active in supporting his wife from behind in the second stage of labor when maximum effort in pushing is required from the mother. Among highland Mayan groups the preservation of modesty is very important. From preadolescent days women never uncover themselves, even for bathing. This same modesty prevails and is expected during labor and delivery. Lights are normally low and the mother's skirt remains in place with the TBA working under it for actual delivery.

Delivery

When the TBA determines that "the time has come" she instructs the mother to begin to push. The midwife usually recognizes this when the mother expresses the feeling of having to defecate. The most common position for delivery continues to be the squatting position, although most TBAs when asked will say that the "proper" position is the "gynecological" position (i.e., laying down). Generally the TBA will attend the women according to the position which the expectant mother prefers. The TBA prepares the floor with a clean plastic cloth with clean sheets on top of it. As the child is born she receives it in a clean cloth and sets it aside as she gives her attention to the delivery of the placenta.

Delivery of the Placenta

Most TBAs consider the delivery of the placenta as potentially one of the most problematic aspects of their work. There are a variety of opinions as to what constitutes a retained placenta varying from fifteen minutes to an hour. They continue to rely on certain herbs, on abdominal massage and on stimulating the vomiting reflex in order to

achieve delivery of the placenta. Once delivered, the placenta is normally buried on the property.

Umbilical Cord Care

Once the placenta is delivered, the umbilical cord is measured two to four fingers from the abdominal wall and tied off. Once tied, the cord is usually cut with scissors. The lack of sterility of the scissors continues to be a serious problem, but one which has never been evaluated. The custom of cauterizing the cord with a candle continues in many of the Mayan communities. Augers are read from the cord and membrane by the midwife indicating the number of babies which the mother is going to have and certain things about the child's future. If, for any reason, it is deemed necessary to cut the cord prior to delivery of the placenta, the loose end of the cord is secured, often by tying it around the mother's leg in the belief that otherwise it will rise in the body and choke her.

Attention to the Newborn

Attention is turned to the newborn once delivery of the placenta is accomplished. The mouth may be swabbed with a clean cloth to remove phlegm. The child is washed with warm water, swaddled and given to the mother. No particular attention seems to be paid to stimulating depressed babies nor to protecting them from hypothermia during the time that the TBA is awaiting the placenta. Many TBAs have UNICEF scales, however, weighing of the infants is seldom carried out.

c. Postpartum Care

Abdominal Binding

After delivery the midwife binds the mother's abdomen to keep the uterus from "falling out of place". The abdomen is often kept bound in this way for a number of months.

Postpartum Visits

The period of postpartum recovery varies from eight to forty days, but the rigidity of adhering to traditional practices seems to be declining. The TBA characteristically visits the mother several times after the birth and is one of the few people with access to the mother in the immediate postpartum period. INCAP investigators have used this fact to very successfully train TBAs to recognize signs of neonatal problems using traditional terminology such as the baby appearing "triste" and in to initiate referral. In addition to inquiring about the mother's health she conducts abdominal massages. In some areas it is also customary for the TBA to perform certain domestic tasks such as cooking some meals and cleaning house. The traditional custom of a large celebration with a meal after the TBA bathes the mother and infant in the temascal and cleans the birthing room is gradually dying out. Little attention appears to be paid to the cord, other than assuring that it is covered.

Postpartum Advice

Evidence indicates that almost half the TBAs instruct the mother to go the health center at about six weeks for a postpartum exam and so their children can begin vaccinations (MOH, Capacitacion y Seguimiento de Comadronas Tradicionales 1986 - 1987).

2. How Many and Where Located

As of 1987, the MOH had trained 13,908 TBAs. The location and distribution of these TBAs can be seen in Annex C. It is more difficult to arrive at an estimation of the actual number of midwives for several reasons. There is a natural attrition and recruitment process going on at an unknown rate, many practicing midwives try to escape official notice to avoid possible sanctions and no really effective registry system exists. INCAP investigators working in Quetzaltenango uncovered numerous TBAs of whom the MOH was not aware. It is probably safe to assume that in addition to the current number of trained TBAs there are another 50% untrained, of whom approximately one-half are identified by Ministry officials. These estimates are based on the information gathered from talking to MOH personnel at the area and district level. A conservative estimate for the total number of TBAs in the country is 20,000.

3. Differences between Ladino and Mayan Midwife Practices

As mentioned above under scope of work, the consultants were directed to concentrate their attention on studying TBA practice in the indigenous population, therefore they are not in a position to fully address this question. One clear difference between the two, however, is the social status which the Mayan midwife enjoys compared to her ladina counterpart. In general, the ladino population considers the midwife to be a necessary evil and would much prefer to be attended in a hospital if such were readily available.

4. Additional Health Tasks

Traditionally, the Mayan midwife has not taken a role in providing health care beyond that narrowly defined as prenatal, delivery and limited postnatal care. A few midwives are also known as healers, but this is because they have a double role, not because healing of illnesses not related to pregnancy is seen as part of their area of expertise. In INCAP's Knowledge, Attitudes and Practices (KAP) Survey at the community level in Guatemala, only 1.7% of mothers consulted the TBA for the diarrheal episode of their child and none consulted the TBA for acute respiratory infections. Anecdotal evidence suggests, however, that the TBA may play a role in the treatment of traditional illnesses such as "mal de ojo", "susto" and "empacho".

The MOH and other sources, however, have reported participation of the midwife as community motivators in vaccination campaigns and studies have shown that TBAs are

referring the mothers to health centers to have their children vaccinated. The consultants were informed that midwives are being given ORS packages to distribute to mothers who have children with diarrhea in some areas, but the impact of this activity is unknown. It appears, then, that the midwife currently does not play an expanded role other than that of health educator and motivator when so encouraged.

On the other hand, INCAP data also show that 80% of mothers know who the closest TBA is and 80% have had a TBA in their home at least once in the last year. This is four times higher than that of any other health worker, indicating the great potential that exists in the midwife for an expanded role under the proper conditions.

5. Payment for Services

It appears that almost all midwives are paid for their services by their clients. Those women who are midwives by supernatural calling see their activity principally as a service and often do not charge anything, but, nevertheless, the family remunerates them in some way, be it cash or kind, if at all possible. Discussions with midwives and review of the literature suggests that the typical charge is Q3 to Q20. It is customary in some communities for the payment to be made after the ritual bath and meal have been celebrated on the eighth day after confinement.

6. Recruitment and Training

a. Recruitment

Among the Mayan population there seem to be several common elements in the recruitment process. There is frequently a supernatural calling. As mentioned above this calling can sometimes be augured by finding certain signs at birth such as part of the amniotic membrane clinging to the child's head. Often, prior to initiating her practice, the midwife will experience dreams in which birthing is a prominent aspect. If the midwife does not arise to accept her responsibilities she suffers illness which is prolonged and severe. At times she will consult a native healer who will tell her that the illness stems from her unwillingness to serve as a midwife. Once she begins to attend deliveries, her illness disappears. This process may go on over several years. Another form of recruitment is through attending births in emergency situations because the regular midwife is unavailable or doesn't arrive on time. If attended successfully then word begins to spread and gradually, over a period of months or years, one is summoned more and more often. A third pattern is that of inheritance, where a young woman learns as a result of watching her grandmother, mother or mother-in-law attend pregnant women. Apprenticeship, as such, however, appears to be uncommon. The most usual pattern is for a number of the above elements to play a part in the recruitment process.

As mentioned above, the adoption of the role of midwife by a woman is not an easy decision to make. She usually suffers resistance from her husband because she is at

times forced to neglect household responsibilities, because she goes out unaccompanied at night and because of the restrictions on sexual relations practiced around the time of delivery in certain parts of the country. Several of the TBAs interviewed reported they had received frequent beatings from their husbands when they first began to deliver babies. The midwife also suffers from the jealousy of other women because of her increased status and her unaccustomed freedoms. The move into full acceptance by the midwife of her new found station is, therefore, often gradual.

One recruitment model which has been attempted over and over and failed is that of training young, eager women who have no previous experience, nor supernatural calling, but who wish to become midwives. At least in the highlands these women are almost never asked to attend births and most programs no longer train any woman who is not already practicing.

b. Training

The MOH is usually able to identify new midwives by asking mothers of newborn babies who come to the health center what midwife attended them and by consulting the civil records at the municipal offices where the parent registers the child and notes, among other things, who attended the mother at the birth. Depending upon available funds, the MOH will invite these newly identified midwives to its 15 day training course.

All of the MOH health areas visited have TBA training programs. The responsibility for the training rests with the professional nursing staff with overall supervision and direction coming from the Area Nurse, major implementation and training responsibility from the District Nurse and support from the auxiliary nurse.

Each area calculates the number of TBAs it has identified who need either training or retraining. At the beginning of the year as part of its planning and budgeting cycle, the Area level sends that number to the central level from where funding for the TBAs @ Q5/day and UNICEF midwife kits are supposed to flow. Complaints were heard that funding is always lower than that requested, funding arrives late in the year when vacations interfere with the Area's ability to effectively undertake the training, and that kits are both fewer than the number needed and increasingly sparse in its contents. (The most recent kits have only scissors, two yards of muslin for making bandages and a kilogram scale.)

The training program lasts 15 working days and is generally held at the district health center. Each TBA receives Q5/day for expenses which, with recent inflation, is considered inadequate, especially since the TBA often travels from a long distance and is usually forced to find a place to sleep. Training is based on the 1980 MOH training manual and includes nine subject areas: orientation to the MOH health services, general hygiene, the delivery kit and its contents, prenatal attention, general concepts of delivery and attention to the newborn, home delivery, puerperium, attention to the newborn and infants and nutrition (including breastfeeding, preparation of formula and weaning). The training is largely didactic. Graphic or other training aids are used only to the

extent to which each health area has invented them. In the highlands translation into one of the Mayan languages is usually necessary and carried out by a bilingual participant. Although illustrated TBA manuals have been developed and produced by the MOH, they are no longer widely available. Most of the TBAs are older illiterate women and stories of many of them nodding off during training courses are common.

In addition to these courses, the MOH tries to program one or two three day retraining courses for previously trained TBAs each year. Central level funding for these courses also falls short of the requested amount. On-going supervision is supposed to occur through the monthly meetings held with trained midwives at the nearest MOH health post or health center. Ostensibly these meetings have a twofold objective - the gathering of information on the numbers of births and training. The reality varies considerably from health center to health center. One center confessed that rather than monthly meetings the various TBAs simply drifted in at different times of the month to report on their activities.

Training content, methodology, financing and goals are discussed in greater detail in the analysis section below.

7. Effectiveness

Despite 30 years of TBA training experience, no evaluation of the effectiveness of the TBA or of TBA training has been carried out on a national scale. The most useful information currently available is that collected since 1984 by Dr Carlos Andrade of the Francisco Marroquin Medical School. The information is based on a population of some 70,000 persons, largely indigenous with slightly over 3000 births in 1987.

Since 1984, when the University's work with midwives in the area began, reported maternal mortality rates have declined from 64.6 per 100,000 in 1984, to 34.5 in 1987 to 0 in 1988. Unfortunately, the utility of these particular statistics is diminished by the small number of cases which they represent (two, one and no cases respectively). Other indicators, however, are very impressive. The percentage of cases referred to the hospital from the project area which resulted in Caesarian section rose from 26% in 1986 to 89% in 1988, indicating a dramatic improvement in the appropriate selection of cases to refer. The percentage of intrapartum/puerperal infection, resulting in large measure from attempts at intravaginal manipulation of the fetus by the midwife during labor, declined from 20% in 1986 to 0% in 1988. The diagnosis of acute fetal distress was made in 100% of the cases referred in 1986 and only 14% of the cases in 1988, indicating a much earlier referral of cases. Perinatal mortality (number of deaths from 28 weeks gestation to seven days of age per 1000 live births) decreased from 36.9 to 25.6. Neonatal mortality rates (number of deaths in the first 28 days of life per 10,000 live births) decreased from 39 in 1984 to 27 in 1987. Although these data are from a limited population, they indicate the enormous impact that TBA training and improved TBA/MOH interrelation can have.

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8.Competition Issues

The existence of competition among midwives was identified in all of the regions visited by the consultants. Midwives were quick to criticize their colleagues and bad feelings were evident if one midwife were to treat another midwife's patient even under the most compelling circumstances. In Santiago Atitlan, for instance, the 19 trained midwives participating in Project Concern International's program for the last several years have tried to impede the incorporation of five new midwives into their group. Discussions with INCAP personnel in Quetzaltenango, however, indicated that there are some midwives to whom other midwives refer complicated cases. Also Project HOPE personnel, in that same Department, stated that through working closely with TBAs they have been able to foster a sense of cooperation. In general, the TBA's jealously guard their patients from other TBAs.

9.Incentives and Disincentives for Referral

a.Incentives for Referral

The MOH training program puts considerable emphasis on the whole subject of referral. There are two classes of patients for whom the MOH requires referral. The first are those whose pregnancy per se is considered high risk - women under the age of 18 years, over the age of 35 years, primigravidas, and grand multiparas (defined as those women with four or more children). The second class are those women who develop complications during pregnancy. In addition TBAs are supposed to refer all patients for at least two prenatal visits for tetanus toxoid and exam as well as postpartum follow-up. The constant reminder by the MOH in monthly meetings and retraining sessions to follow these recommendations and the underlying fear of sanctions if they don't, is one incentive for referral.

The ability of the health services, especially the hospitals, to resolve problems beyond the capacity of the TBA and often save her patients' lives is another strong incentive for referral.

b.Disincentives for Referral

There are a number of disincentives for referral by the TBA to the health services. The first is the poor treatment which the TBA often receives at the health establishment. Although there are exceptions, as a rule the TBA is seen as being ignorant, dirty and dangerous. The very history of relationship between the western, male, ladino doctors and the traditional, female, Mayan midwives means that the midwife often postpones to the last possible moment the decision to refer a patient to avoid the scorn and abuse which will be hers at the hospital. The patients that arrive are often in serious medical condition reinforcing the physicians' opinion that the midwives are dangerous. Midwives are met in the hospital with severe reprimands from the physicians and nurses.

Even if the midwife refers the patient, there is even greater resistance to going to the hospital from the patient. The reasons patients resist going to the hospital are multiple but include the following. First there is distance and expense. Often the patient, particularly if she is in labor, has to be carried down mountain paths to a road, then a vehicle has to be located and rented for what may be a long and uncomfortable trip to the health establishment. Such a trip requires the abandonment of the woman's family and all the supporting social structure involved therein and the entrance into an impersonal institution where few people may speak her language. Once in the hospital the extreme modesty which has characterized her life from childhood is violated by strange men and women. There is fear of "operation" often associating such with death and sterilization. There is also the economic reality that if the mother does die in the hospital the family must pay a funeral parlor some hundreds of Quetzales to take the body home for burial. It is not surprising, therefore, that there is resistance to going to the hospitals. There appears to be a widespread, fatalistic attitude that if one is going to die it is better to do so in the home.

Referral to the hospital may also decrease the TBA's prestige in the community demonstrating her incapacity to handle problems.

B. Institutional Interaction with the TBA

1. MOH

In addition to training activities discussed above, there are two other opportunities during which the TBA may interact with the MOH system - during prenatal care and in the case of complications and referral at the time of delivery. The MOH course stresses that all women should be seen at least twice in an MOH facility during their pregnancy and teaches the TBAs to recognize and refer high risk pregnancies. Some TBAs travel with their patients to the health center and in some clinics the TBA participates with the doctor or nurse in the exam of the patient turning the visit into a training opportunity. MOH norms insist that all women less than the age of 18, primigravidas, women over the age of 35, and grand multiparas deliver in a hospital and the TBA is expected to refer these women as well as those who suffer prenatal/delivery complications. The TBA often travels with her patient to the hospital in the case of a complication during labor. Unfortunately, all too frequently the reception offered the TBA by the medical staff is scorn, scolding and arrogance. This, of course, creates serious obstacles to the early referral process as discussed above.

2. PVOs

ASOCIACION DE SERVICIOS COMUNITARIOS DE SALUD (ASECSA)

ASECSA is no longer involved in TBA training. However, they have an excellent TBA training manual a few pages of which is included in Annex F.

PROJECT CONCERN INTERNATIONAL, Santiago Atitlan, Solala

The PCI project began in 1976 when it assumed responsibility for the operation of Clinica Santiaguito from a United States based church group after the 1976 earthquake. PCI continued the curative activities of the clinic and gradually introduced a preventive orientation with a triple focus - promoters providing health education and basic curative care in their communities, nutrition centers for malnourished children identified by promoters or others and TBA training and supervision.

PCI began some training of TBAs in 1978. In 1983 PCI worked with the local MOH health center staff to develop joint training programs which resulted in retraining of all TBAs in 1984. Gradually PCI has assumed more and more responsibility for the on-going education of TBAs through monthly meetings. In 1987 it was decided that previous training programs had not been as effective as hoped for because they had been implemented in a very autocratic and domineering fashion and that monthly meetings were too formal thus limiting their effectiveness. The Tzutuil-speaking program managers, a physician and a professional nurse, developed and applied a questionnaire including a practical demonstration to learn what the comadronas knew and what they actually did with regard to prenatal, postnatal and delivery care. While this was going on, the attitudes and understanding of these western trained professionals were undergoing some changes as they developed an appreciation and respect for the many positive practices they encountered among the TBAs. As a result, current training programs are being conducted with much more cultural sensitivity. PCI believes it is too early to expect results from this new approach, but expects to see them by 1990.

PCI uses the MOH training manual and the MOH TBA manuals (the only site in which the investigators found such manuals) to guide training content, but they adjust training methodologies to local needs using dolls, diagrams, etc., as appropriate. The course is four hours per day for five days, every three months.

The principal problems with TBA practice encountered by program managers were the following:

- TBAs have the mothers begin to push too early in labor
- TBAs practice inadequate hygiene during delivery
- TBAs sometimes do not sterilize the scissors and umbilical tape. This combined with the fact that the MOH has discouraged the traditional practice of cauterizing the umbilical cord is worrisome. (There were three cases of neonatal tetanus last year.)
- TBAs do not give adequate attention or stimulation to the newborn, largely ignoring it until the birth of the placenta

- Many mothers do not visit the TBA until late in the third trimester, making adequate prenatal care more difficult

Other points made by PCI staff were the existence of competition and rivalry among the TBAs. For instance the current group of 19 active midwives have objected to PCI training an additional five midwives who have recently been identified. They state that the TBAs are very highly respected in their communities and that they do not charge for their services, seeing it as a calling rather than a business. Staff also identified the years of mistreatment by practitioners of western medicine as being a barrier to acceptance by the population of "modern" practices. The majority of the TBAs are elderly and illiterate, generating special training obstacles.

MARYKNOLL MISSION HOSPITAL, Jacaltenango, Huehuetenango

The Maryknoll Hospital has been functioning in this community since 1962. Promotor training was one of Sister Rose Cordis', the hospital's founder, first priorities, followed in 1967 by the development of a midwife training program operated by another Maryknoll sister who was a trained midwife. The program had no supervision component and focussed on hygiene. The program functioned until approximately 1972 at which time the MOH assumed training and supervision responsibilities.

At the request of UNICEF, the hospital and the MOH health center in San Antonio Huista will jointly implement a UNICEF financed attempt to develop a new training methodology for TBAs in the area. The Maryknoll Hospital is uniquely prepared to participate in this process because most of the professional and auxiliary nurses in the area have been trained by them and there are strong and positive relationships with the local population, local midwives and MOH staff. The Mam speaking nurse from the health center will spend six months full time interviewing and observing the midwives. She will be assisted by four auxiliary Mam-speaking nurses from MOH health posts who will work eight days per month in this activity. This team, assisted by Sister Jean, herself a nursing educator, and UNICEF experts will try to understand why TBAs practice as they do and why they are resistant to the adoption of certain MOH norms. The result should be the development of a much more culturally sensitive program designed to build upon traditional beliefs, not to totally disregard them. If successful, UNICEF funding provides for the gradual expansion of the program to include all of Huehuetenango, San Marcos and Quiche.

CLINICA MAXENA, Santo Tomas la Union

The Maxena Clinic was founded some 23 years ago with funding from the Catholic church. The clinic has both a curative and a preventive program. The preventive program, coordinated by health promotor Mateo Poz, has a promotor training and support program with a promotor in each community and a TBA training and retraining program. Work with TBAs began in 1968 and originally consisted in training and preparation of TBA kits. TBAs were given sufficient sterilized equipment for two or

three deliveries and then would come to the clinic to have equipment re-sterilized. Every year they would come to have their kits reviewed and replenished as needed. Later they began with formal training and retraining programs for one week twice per year. Currently the TBAs meet for retraining two or three times per year. There are 50 TBAs participating in the program. A Mayan TBA actually works for the clinic providing prenatal care, advising other TBAs and participating in training programs. The program will train a new group of TBAs this year in two day sessions every fifteen days for seven months. The two days include two half days for travel time, so total class time will be 14 work days.

The Clinic uses the ASECSA "Materno Infantil" and the MOH manuals as guides and supplements training with graphic materials. All training is in Quiche and is designed to complement the knowledge each already has from practical experience, rather than replace it. The education is "participatory" using group discussions and questioning of participants to enable them to express their understanding and build upon their actual knowledge.

The most difficult attitude to change is that of fear of the hospital. The patients prefer to die at home (where they do not have to pay several hundred Quetzales to a funeral director to remove the body from the hospital). They fear being in an environment where they confront language barriers, where their natural modesty is violated by strange men and where they may be subjected to an operation.

The clinic is attempting to expand the midwives' role to include health education activities. They also report that oxytocics are sold and even injected by pharmacists upon request from the family as a means of speeding up labor.

PROJECT HOPE

In 1976 Project Hope sent supplies and a team of medical professionals to Guatemala to assist with the earthquake relief efforts. Since then the organization has carried out a number of programs in the country, primarily in the Quetzaltenango/San Marcos areas.

Project Hope has an experienced field staff, composed of Guatemalan nationals, who have been working with community-based health workers since 1977. The organization's current project, now under the direction of Dr. George Flores, began in 1985 and has as its focus the training of community health workers to educate mothers in the use of ORT and the promotion of immunizations in 188 communities in the western highlands of Guatemala. In the past 3 years the program has trained 853 community-based health workers (CBHWs), of whom 22% are TBAs (total 180).

The CBHWs receive a 7 day training course, taught by the rural health technicians/field supervisors. The content of the course includes health education in the community, the use of ORT (both packets and home-based), the promotion of vaccinations, hygiene, breastfeeding, home gardening, latrine construction and how to obtain clean water. In

addition, Hope has trained TBAs in a 15 day course, based on MOH guidelines for TBA training.

At the end of the 7 day CBHW course, follow-up supervision is provided by the field staff (rural health technicians). For 3 months post graduation the CBHWs are visited twice a month, then once a month thereafter. During these supervisory visits they assist the CBHWs in leading mothers' groups, conduct home visits and reinforce lessons learned in the course. The supervisors do not supervise the TBAs in their midwifery practice, but concentrate on reinforcing their role in promoting child survival strategies.

An AID evaluation of the project, submitted in December 1988, found that the program was able to successfully develop a system for identifying and targeting high risk families and that accessibility of ORS packets and information has increased. Approximately 83% of target area mothers reported knowledge of the use of ORT packets or home-based solutions and 55% of mothers reported that they used ORT during their infant's last episode of diarrhea. Immunization coverage increased for all age groups, however, the increase in coverage for tetanus in women ages 15-49 was particularly notable (from 1% to almost 40%).

The Project Hope staff consider their TBA training program a success and feel that their training program has had a positive impact on the type of care being given to mothers and infants by TBAs. Guillermo Nowell, Project Hope field supervisor, is a highly regarded nurse educator who has provided both regular consultation and collaborated with the MOH as a trainer of TBAs.

The TBA training course, while adhering to MOH guidelines, uses innovative participatory learning techniques. The most outstanding features of the program are:

- Special efforts are made throughout the program to encourage the TBAs to work together and support each other professionally. This is a significant and positive step because it appears that in most areas TBAs are extremely "competitive" and work in isolation. Guillermo Nowell stated that he personally knows of many instances where TBAs in the project areas have called another TBA for advice in difficult situations. He states, "I tell them that since they were all chosen by God to be TBAs, God wants them to work together."
- The program encourages a policy of younger women accompanying the TBAs to births, as "assistants." This is not common practice in most areas of Guatemala and has the potential to develop a younger, more experienced cadre of TBAs for the future, without "interfering" with cultural norms.
- TBAs are actively being used to promote child survival strategies. The program staff feel that this has been particularly successful in the areas of ORT and immunization.

Whereas MOH health services see approximately 4% of pregnant women for prenatal care, Project Hope trained TBAs/CBHWs have achieved a coverage rate of 80% in some areas.

COOPERATIVE FOR AMERICAN RELIEF EVERYWHERE (CARE)

From 1984 to 1988 CARE supported a Village Health Outreach Program through the Ministry of Health which included the construction of some 67 health posts and the training of promoter and TBA personnel in the villages served by those centers. Some 300 TBAs were trained during the five year project period. Villages served were in the Departments of Huehuetenango, Quetzaltenango, Isabal, Baja Verapaz and Chimaltenango. CARE anticipates funding for a new initiative in child survival with an emphasis on health education through community leaders including TBAs in 1989.

ASOCIACION GUATEMALTECA DE EDUCACION SEXUAL (AGES)

AGES is an organization with considerable successful experience working in the area of family life education both in the urban as well as the rural indigenous environment. Although AGES has not worked with midwives directly they have recently completed data collection in a survey of six Mayan villages with a number of questions touching upon the actions of midwives. cursory review of the information by the authors of this report show the following:

- In some villages the midwife is the person most often mentioned as the one who could best teach natural family planning methods (other forms of family planning are largely rejected).
- That the TBA is the most frequent person mentioned when asked to whom should one turn when there are problems during the delivery. The reasons mentioned for this include cost, proximity, custom and trust.
- Most patients expect that if the TBA cannot handle the complication then the mother must go to the hospital, but it seems that a hierarchical relationship is clearly present with the TBA being the first and preferred point of contact.

3. Donor Agencies

UNITED NATIONS CHILDREN'S FUND (UNICEF)

For approximately the last ten years UNICEF has supported the MOH training programs largely through the provision of UNICEF midwifery kits and per diem for trainees. UNICEF sponsored a 1985 evaluation of the MOH's training program which

reportedly concluded that the training methodology used by the MOH was autocratic, attempted to "westernize" traditional practice and, in general, served to undermine and discredit their work. Since 1986, UNICEF has been preparing a project to conduct TBA training in such a way as to fortify traditional practice, not undermine it. A funding agreement between UNICEF and the MOH has recently been signed and the three phased project will get underway this year. The first phase, lasting six months, involves investigation and training materials preparation. (This is discussed more fully under the Maryknoll Hospital above.) The second phase will see the training activity extended throughout the Huehuetenango area and into San Marcos and Quiche. The last four months will be spent on evaluation.

UNITED NATIONS FUND FOR POPULATION ACTIVITIES (UNFPA)

From 1981 to 1988 UNFPA supported MOH midwife training in 5 areas through its Extension and Strengthening Health Services Project.

The goals of the project were to extend MCH institutional coverage in the designated areas; to improve the early detection and appropriate follow-up of cervical and breast cancer; strengthen the regionalization plan; train all primary health care workers; assure accurate health information; strengthen personnel, supplies and equipment as needed; develop research studies aimed at identifying the obstacles to good communication between health services and the community; promote changes in attitude, activities and practices in families in the community and strengthen, to the extent possible, administrative deficiencies. In the opinion of UNFPA officials, the project faced considerable administrative problems and has never been adequately evaluated.

AGENCY FOR INTERNATIONAL DEVELOPMENT (AID)

AID, like UNICEF and perhaps other donors, has been supporting TBA training programs through the MOH for more than fifteen years. Unfortunately, the nature of that support and the results are not easily reconstructed. AID's most recent effort was in the training program of the Primary Health Care Component of the Community-Based Health and Nutrition Systems Project of Guatemala. This project was signed between the two governments in 1980 but did not actually begin operations until 1982. The project, among other things, intended to establish an ongoing training program for community-based personnel and for their trainers and supervisors, and put in place supervision, information and evaluation systems in the three target Departments of Totonicapan, San Marcos and Solola. TBA training was an important aspect and training manuals were prepared. Unfortunately, project implementation coincided with a period of intense social unrest in the country, frequent personnel turnovers at the MOH policy level and a certain distancing from AID funded projects. The net result was the isolation of the project and its non-sustainability.

4.Others

UNIVERSIDAD FRANCISCO MARROQUIN

Like medical students at the public university in Guatemala, UFM students in their last year have to spend six months in a supervised rural practice, generally in an MOH health center or similar post. The UFM program, directed by Dr. Carlos Andrade, is located in the San Juan, Sacatepequez area and has during its five years of existence nurtured a close and cooperative interaction between medical students and TBAs. The objective of this interaction is to improve the information system, increase both pre and postnatal care and improve the referral system. These ends are achieved through a daily and informal interaction between student and TBA and through regular monthly meetings of TBAs, medical students, UFM staff and MOH staff. The daily interaction involves prenatal care given by the student upon referral of the TBA, often with the TBA present. TBAs also feel free to ask the students to visit their sick or complicated patients in their homes if deemed necessary. This is facilitated by the fact that the student lives in the village he is serving during the entire six month period. The UFM program has been successful in recruiting and maintaining the participation of more than 90 midwives, an indication that the midwives believe that they are benefitting from the relationship. The monthly meetings are not strictly didactic in nature. Rather discussion revolves around cases and complications which individual TBAs have faced in the previous months and which they present to the group. The TBAs present are asked if they agree with the course of action taken by the TBA presenting the case. If the TBA took appropriate action her behavior is reinforced through acknowledgement by the other TBAs, praise from the group leaders, applause and repetition by the group leaders (MOH nurse and Dr. Andrade) of the health principles involved. If inappropriate action was taken the opportunity is presented for the other midwives to correct their peer's behavior with reinforcement from the group leaders.

Notable in this program are the efforts to assure that all personnel understand and have an opportunity to participate through translation into native languages and the high degree of respect shown to the midwives by the UFM and MOH staffs. The number of appropriate referrals from the communities served by this program to MOH hospitals has greatly increased and a sense of trust between Roosevelt hospital staff and the midwives has reportedly been established. The program began with some twenty midwives and currently has close to 100 active. This is also the only area in which we saw an effective birth registration system operating with almost complete coverage with the MOH's birth registration form.

INSTITUTE OF NUTRITION OF CENTRAL AMERICA AND PANAMA (INCAP)

INCAP has worked with TBA training in several of its health projects including the Integrated System of Nutrition and Primary Health Care (SINAPS) Project, the Solala Project and the Patulul Project. As part of the SINAPS Project the first TBA manual based upon a TBA "job description" was prepared. It was based on concrete, discrete

and identifiable TBA tasks. The training was conducted in two to three hour sessions once or twice per month and at sites very close to the TBAs' homes, combining two or three villages at the most. Unfortunately, the training encountered numerous difficulties deriving in large part from the fact that the majority of the TBAs were elderly, illiterate and very unsophisticated. This made the performance of such important tasks as measuring and recording weights most difficult. INCAP officials involved in the project mentioned that the most difficult group to train under the SINAPS project were the TBAs. The TBAs were not able to use the manuals and the SINAPS manual is now only of historical interest. No formal evaluation of training impact was done.

As a part of the Solala Project, initiated in 1976, a "Simplified Prenatal Care Manual was prepared which emphasized the concept of high risk, the levels of prenatal, delivery, post-partum and perinatal care." (Delgado, 1980) Training in this project was informal and unstructured. No training evaluation is available to our knowledge. The Patulul project, carried out in the Department of Suchitepequez had a maternal care program emphasizing early pregnancy detection, prenatal care, determination of delivery risk level and postpartum and perinatal care. "The empirical midwives were identified and trained in informal settings. Special emphasis was given to childbirth management and care of the newborn. The midwives were trained to obtain birth weights using a simple scale, and to refer high-risk cases" (Ibid). The investigators have not seen evaluations of the TBA training component of this project either.

INCAP currently has a number of activities underway which involve TBAs. It has a highly qualified, full time advisor who is assisting the Ministry of Health in the revision of its TBA training manual. INCAP also has a major effort underway to evaluate TBA practices and develop options for improving them in Quetzaltenango and is involved with TBAs in a second study in Santa Maria de Jesus, Sacatepequez.

The major study entitled "Evaluative Investigation of Maternal Child Care Provided by Traditional Midwives and Options for Its Improvement has three components - a Knowledge, Attitudes and Practices (KAP) study of TBAs, mothers and husbands in relation to the detection and management of high risk pregnancies, the capacity of the health system to appropriately treat these cases and the introduction of a TBA training model to improve case management at the community level. The study has completed the data collection of the first component and is beginning analysis.

As part of a series of studies of infant and childhood diseases and nutrition centered in the community of Santa Maria de Jesus, Sacatepequez, INCAP investigators have established especially close relationships with the TBAs in the town. Among other things the investigators carried out a retrospective, case-control study of risk factors associated with intrapartum and neonatal mortality. The study identified five risk factors - illiteracy of the mother, first pregnancy, birth interval of less than 14 months, non-use of modern prenatal care services and a specific midwife. There were two factors particularly associated with intrapartum death - intramuscular oxytocin during labor and more than three vaginal exams by the TBA. The investigators are currently conducting a longitudinal study to validate these risk factors in pregnant women and newborns, to

achieve early identification of morbidity and to evaluate the effectiveness of community level interventions.

The investigators interviewed three midwives in this community with the following as general observations:

- The midwives universally use intramuscular oxytocics in the majority of patients in order to hasten labor. This practice is not only accepted by the community, but is reportedly demanded by them. Most of the midwives knew that this practice was condemned by the MOH. (The investigators purchased a 5 IU vial in the local pharmacy for 2Q.)
- All of the midwives had been trained by the MOH.
- All reported attending deliveries in the "gynecological" position.
- All had attended their first deliveries in emergency situations when the normal TBA was not available and gradually gained a reputation and clientele.
- There was a definite sense of competition among the TBAs and readiness to point out what their competitors were doing wrong.
- All used scissors to cut the cord.

5. Donor Coordination

There does not appear to have been any serious efforts at donor coordination in TBA training in spite of the many years of involvement by several different donors and non-governmental organizations (NGOs).

III. ANALYSIS OF TBA ISSUES

A. Training

1. Appropriateness of Western Medical Model

"In order to be effective, any maternal/child health services and training programs must take into account the local beliefs, practices and specialists associated with pregnancy, delivery and postpartum care." (Kelly, 1956)

Unfortunately, this excellent philosophy is rarely followed. In recent years, there has been an increased awareness that the vast majority of "traditional customs" not only have merit, but they are usually the most effective interventions for the environment in which

they are practiced (eg; upright position for delivery). While it appears that attempts are being made to incorporate the philosophy of respect for indigenous beliefs into TBA training programs, the overriding tone of the courses is still one of condemnation of traditional practices and the imposition of Western medical routines. Many of the changes in practice that are advocated are not only inappropriate for deliveries at home, but also they have little or no basis in scientific rationale. Rather than improving care for mothers and babies, some of the western based medical practices advocated in the training programs may actually be contributing to increased maternal and neonatal mortality and morbidity.

"Ten years ago there was so little anthropological research about birth that the superiority of biomedicine and its associated pedagogy could still be assumed; by now, the work of the last decade has produced a deep scholarly appreciation of ethno-obstetric systems of knowledge and practice which, however, has not yet entered into the design of training programs to any great extent. What has been taken into account even less is the mode of knowledge transfer on which indigenous obstetric systems have relied in their own reproduction." Dr. Bridgitte Jordan, *Cosmopolitical Obstetrics: Some Insights from the Training of Traditional Midwives.*

The director of one of the private TBA training programs stated, *"A common misconception exists that training consists of translating and simplifying an obstetrics textbook."*

2. Realistic Training Expectations

A 1988 MOH/MCH Division report on the training and in-service education of TBAs states as its objectives:

- a) The early referral of pregnant women and appropriate identification and referral of high risk pregnancies through the training and in-service education of TBAs.
- b) The education of the community by TBAs on maternal/child health problems, identified by the MOH, and the carrying out of activities by the TBA to reduce these problems.
- c) Evaluation of the impact of TBA activities.
- d) The supervision and monitoring of the activities of TBAs.

These are excellent objectives and if implemented, would probably result in a significant improvement in the overall health of mothers and infants in Guatemala, given that TBAs attend over 60% of all births. The gap between the stated objectives of the Ministry and their ability to carry them out is a wide one for a variety of reasons, some of which include:

a) Lack of Resources

There is no budget for TBA training and supervision activities. Funding comes solely from outside agencies such as UNICEF, USAID, UNFPA, CARE, Project Hope, and Project Concern. Monies available for TBA activities are apparently erratic, making the planning and implementation of an effective national program strategy difficult, if not impossible.

b) Referral System and Care for High Risk Cases

The referral system, particularly in the rural areas, for high risk cases appears to be inadequate, at best. This in addition to problems with communication, distance, geography, cultural differences, lack of transportation and area hospitals which are understaffed, overcrowded and poorly equipped makes referral of high risk cases problematic, even when they are detected.

c) Lack of an Established Working Relationship between TBAs and Ministry Health Personnel

An essential pre-requisite in order for the stated MOH goals to be achieved is the existence of an on-going, collaborative working relationship between the TBAs and MOH health personnel in each area. This basic requirement does not appear to exist in most areas. It is totally unrealistic to expect that TBAs will refer their patients for medical treatment or carry out health education/child survival activities unless the relationship between themselves and the established health care system is one of mutual respect and support.

Although many MOH health personnel interviewed expressed positive attitudes towards TBAs, a constant theme throughout the field visits was the mistreatment of TBAs by medical staff when they brought patients into the hospitals or health centers. The standard method of dealing with TBAs when they refer complications appears to be scolding, instead of positive reinforcement.

In the highland communities, the problems is often exacerbated by cultural and language barriers. The vast majority of health personnel are spanish-speaking ladinos, while the majority of TBAs are Mayan speaking.

Unless attitudes by health professionals towards TBAs are changed, it is unlikely that any of the MOH goals can be met.

3. Educational Methodologies

The basic MOH TBA training course takes place over a period of 15 consecutive working days. The in-service courses are conducted for a period of 3 days once per year. These courses generally take place at the district health center, requiring most of

the TBAs to travel long distances and stay until the training is completed. In addition, monthly meetings for the purpose of reporting births and supervision and reinforcement of training contents are supposed to be held at the local health post.

The MOH has developed a pair of manuals to be used in the TBA training courses. One manual is for trainers of TBAs and the other is for the TBA herself. The trainer's manual is divided into units and covers such themes as: roles and responsibilities, orientation, course content, estimated times for each theme, methodology and materials/equipment needed. The TBA manual covers major themes taught during the course such as hygiene, and has fewer words and more drawings than the trainer's manual.

The basic teaching methodologies suggested in the manual are discussion and demonstration. The manual instructs the trainers to be creative and involve the TBAs in the learning process, but gives little guidance on how to accomplish this. There are few illustrations to stimulate the instructors' imagination or serve as examples/models. Innovative participatory teaching/learning techniques are not outlined (eg; sample role playing, games). The manual is more suited to basic nursing instruction than as a training guide for trainers of a traditional illiterate population.

A frequent comment about the training programs from people interviewed was that they were "boring" and that the TBAs were required to sit for long periods of time and often fell asleep. Lack of appropriate teaching materials was a universal complaint. There appears to be little attempt in the training to connect the material being taught (which is based on biomedical concepts) to the TBAs way of life or experience.

The primary form for both learning and the communication of information in the TBAs' daily life is "story telling." When asked a question about something, the common response is to tell a story about an event which relates to that question. "Story telling" as a way to teach concepts and information should be one of the primary educational methodologies used in TBA training.

The majority of TBAs are illiterate and most have never attended school. The TBAs are accustomed to learning by observation and participation, not by reading or verbal interaction. Most of the material being taught contains concepts which are both abstract and totally new to them. To expect the TBAs to sit in a "classroom type setting" for 15 days and absorb and retain a significant amount of didactic material is simply unrealistic. It is also difficult for trainers to maintain enthusiasm and interest over such a long period of time.

4. Technical Expertise and Experience of Trainers

TBA training is generally conducted by the area nurses, the majority of whom have little or no experience in training, particularly with traditional, Mayan-speaking, illiterate populations. In addition, unlike in many other countries, where there is a strong tradition of midwifery in nursing, the experience of "managing" obstetrical

cases/problems for most nurses in Guatemala is limited. According to the DHS Survey, nurses attend only 3.6% of all births in Guatemala. Therefore, most of the trainers of TBAs have less obstetrical experience than the TBAs themselves. This coupled with the trainers lack of orientation to the realities of attending births in the home versus the institutional setting, makes successful training problematic.

The critical area of "training of trainers" within the midwife program appears to have been given little attention in Guatemala, making measurable achievements unlikely until greater efforts are made to develop a cadre of health professionals skilled in effective training methodology.

5. Training Content and Impact on TBA Practice

As Dr. Polly Harrison stated over a decade ago, the amount of material that the TBAs are expected to learn during the course of the standard training is unrealistic. In addition, much of the course content is inaccurate and inappropriate for the environment in which the TBAs practice.

For the purposes of discussion, the training content has been divided into the following categories:

- a. Harmful practices TBA training courses have generally discouraged on which training appears to have made a positive impact.*
- b. New practices that have been encouraged during TBA training courses on which the courses appear to have made a positive impact.*
- c. Beneficial traditional practices the TBA training courses have generally labeled "harmful" that have been replaced by practices which may, in reality, be increasing maternal/infant morbidity and mortality.*
- d. Neutral, or possibly beneficial traditional practices the TBA training courses often address, which deserve a re-evaluation in training approach.*
- e. New TBA practices which warrant serious program and training inputs.*
- f. Other*

a. HARMFUL PRACTICES THE TBA TRAINING COURSES HAVE GENERALLY DISCOURAGED ON WHICH TRAINING APPEARS TO HAVE MADE A POSITIVE IMPACT

Encouraging the Mother to Push in Labor Before Full Dilatation of the Cervix ("early pushing")

The practice of encouraging the mother to push in labor before full dilatation of the cervix (prior to 2nd stage) appears to have been widespread prior to MOH and PVO TBA training efforts. TBAs encouraged "early pushing" in the erroneous belief that it would result in a faster delivery of the infant.

Physiologically, the practice of pushing before full dilatation has the opposite effect, often resulting in both prolonged labor and significantly increased pain and exhaustion for the mother due to swelling of the cervix.

From interviews with TBAs and health personnel, it appears that the training courses have been successful in reducing this practice, although it still remains a problem in some areas, often due to "pressure" from the families (usually the mother-in-law or husband) who want to speed up the birth.

Giving the Mother Alcohol to Drink During Labor

In some areas of the country it is common practice to give the mother large quantities of alcohol to drink during labor "to help the pain." Often the TBA drinks with the mother (no explanation was given other than "custom"). Several nurses reported seeing both mothers and TBAs drunk on the floor after deliveries, with the newborn lying unattended.

Aside from rendering the TBA and/or mother incapacitated and less capable of conducting a safe delivery and caring for the newborn, ingesting large amounts of alcohol has the physiological effect of diminishing or stopping uterine contractions (therefore prolonging labor or stopping it altogether). Before the discovery of the drugs Ritalin and Terbutaline in the 1970's, alcohol (both oral and IV) was used to stop premature labor. Alcohol also depresses respirations in the newborn.

Although drinking alcohol in labor is still a problem in some areas, it appears that the training programs have had a positive impact on reducing this practice.

b. NEW PRACTICES THAT HAVE OFTEN BEEN ENCOURAGED DURING TBA TRAINING WHICH APPEAR TO HAVE MADE A POSITIVE IMPACT

Handwashing

Traditionally, it was not normal practice for TBAs to wash their hands prior to doing vaginal exams or conducting the delivery of the newborn. Conducting deliveries with unclean hands can contribute to increased intrapartum/postpartum infections.

Although difficult to evaluate, it appears that the training emphasis on handwashing has resulted in a change in practice. Most TBAs stated that they washed their hands, although there are a number of reports that they often do not use soap.

High Risk Screening and Referral

The concept of screening pregnant women for high risk conditions (ie; breech and transverse position, twins, bleeding in pregnancy) and referring these cases to the health post/hospital has been a focus of TBA training efforts. The detection of high risk pregnancies in the community, in conjunction with appropriate medical intervention has been demonstrated to be one of the most effective means of reducing maternal/infant mortality and morbidity worldwide.

A health post in the San Marcos area has an excellent system for the referral of high risk complications which uses drawings of various types of complications which the TBAs choose from and send or bring in with the high risk patient.

All TBAs and health personnel interviewed stressed the concept of high risk screening and appropriate referral, indicating training impact in this important area. There appears to be a wide variation in the successful implementation of a referral system between TBAs and the MOH however. The major constraints are:

- a) Geography/distance from health post/hospital along with transportation which is difficult/inadequate/expensive
- b) Historically, referrals were made too late, as a result most infants/mothers died by the time they got to the hospital, creating a lack of confidence that referral made a positive difference in the outcome
- c) Mayan fear and distrust of the established medical system by the indigenous population (ie; fear of involuntary sterilization, mistreatment) and hospital practices which are contrary to traditional customs (delivery with the mother lying flat on her back instead of upright; different food; bathing routines)
- d) Cultural beliefs such as: extreme modesty (Mayan women never uncover themselves); deep rooted fear of operations due to the belief that one never completely "heals" afterwards; husbands not wanting their wives to be examined/touched by another man (male physician)
- e) TBAs have often been treated poorly and scolded by medical personnel, instead of being positively reinforced, when they have brought patients into the health post/hospital, which has made them reluctant to continue referring mothers in high risk situations

f) The expense that is demanded from the family by the funeral parlors ("funerarios") to recover a body from the hospital, (in the range of 80-150 Q), is more than most rural families can afford. This discourages families from transferring the mother/baby to the hospital, especially if death is "believed" to be likely/inevitable.

Nutrition Counseling

Although nutritional beliefs and practices vary from area to area, food restrictions during pregnancy and lactation are common in the rural populations. Customarily, foods are divided into those which have "hot" or "cold" properties and each category is thought to affect the body in different ways. It is considered important to eat a balance of foods which are "hot" and "cold", depending on the nature of the condition. Mothers are generally advised to restrict foods classified as "cold" during pregnancy. Foods such as beans, eggs, cabbage and milk are often classified as "cold" and are thought to restrict blood flow, make the mother sick, stop the flow of milk or cause the infant to be "colicky." Certain greens, spices and chicken soup are thought to "heat" the body and are encouraged. In addition, in some areas, it is common for TBAs and female relatives to actively discourage pregnant mothers from eating "too much" or normal/adequate amounts of food in the belief that the baby will become too large, resulting in a difficult labor.

The training courses have taught the TBAs to encourage mothers to avoid food restrictions and eat adequate amounts of nutritional foods. Several of the TBAs interviewed stated that they now tell mothers "to eat everything."

Training which incorporates the belief system of classifying "hot" and "cold" foods and teaches the TBAs to encourage women to eat foods according to this system will probably be the most effective in modifying dietary behavior.

The tradition of exclusive/prolonged breastfeeding has remained strong in the Mayan population and been supported in TBA training programs. The training also encourages the importance of giving colostrum (discarding of colostrum and prelacteal feeding is a problem in some areas), to initiate breastfeeding early and TBAs are usually taught how to advise mothers who have problems with insufficient milk production. Given the anti-infective, anti-diarrheal and birth spacing benefits of breastfeeding, this is an important area of training emphasis.

Referral of Pregnant Women to Health Posts for Vaccinations/Prenatal Care

The training courses have emphasized the importance of the TBAs encouraging pregnant women to go to health posts for vaccinations (tetanus toxoid) and prenatal care. This appears to have been more successful in some areas than in others and may depend somewhat on the relationship that the TBA has with local health personnel, cultural beliefs about vaccines and perceived benefits of prenatal care by the community.

Attention to the Newborn

Bathing of the newborn and observing for problems during the period immediately following birth and the first week postpartum is generally taught to TBAs during training. Changes in practice in this area are difficult to evaluate, particularly the TBAs understanding of what signs are important to observe for, however, most TBAs stated that they bathe the newborn.

Areas relating to care of the newborn postpartum which appear to need additional training efforts/emphasis are temperature maintenance (prevention of hypothermia) and stimulation/resuscitation of the depressed newborn. A common traditional practice is for the TBA to wait for the placenta to be expelled before wrapping the newborn and cutting and tying the cord (in the belief that otherwise the placenta may move up the mother's body and choke her). Waiting until after the delivery of the placenta to cut the cord is not a harmful practice in and of itself, however the newborn needs to be wrapped and/or held by the mother from the moment of birth in order to prevent complications of hypothermia.

The importance of preventing hypothermia in the newborn needs to be a continued area of training emphasis, and will probably be more effective without insisting that the TBAs abandon the practice of waiting for the placenta to deliver before cutting the umbilical cord.

Resuscitation of the depressed newborn appears to need further attention during training. A practice which appears common in some areas is for the TBA to immerse the placenta (while still attached to the depressed newborn) in hot water, in an attempt to revive the infant. Many TBAs seem unaware that there is anything that can be done to stimulate respiration in a newborn that is not breathing. Simple techniques such as keeping the infant warm, firmly massaging the spine in an up and down motion, clearing the airway and even "mouth to mouth" resuscitation should be emphasized in the training program.

c. BENEFICIAL TRADITIONAL PRACTICES THE TBA TRAINING COURSES HAVE GENERALLY LABELED "HARMFUL" THAT HAVE BEEN REPLACED BY PRACTICES WHICH MAY, IN REALITY, BE INCREASING MATERNAL/INFANT MORTALITY AND MORBIDITY

It is a common phenomena in training programs in developing countries throughout the world for Western trained/institution based health personnel to make the assumption that institutional practices and procedures are universally the most "correct" and "safest" method of doing things. As a result, attempts are frequently made during training to replace "traditional" practices with institutional ones, without sound scientific evidence that institutional practices transferred to the home or community setting result in decreased morbidity/mortality. The result of replacing "traditional" practices with those

of the "institution" without the appropriate risk versus benefit analysis, is in reality, often a negative one.

TBA training programs in Guatemala appear to have suffered from similar problems. There are several practices which warrant a re-analysis in training approach:

Delivery Position

The traditional position for delivery (as in most other parts of the world) in Guatemala is "upright", with the woman either kneeling or squatting to give birth. There is a significant amount of current scientific evidence that the upright delivery position is by far the most beneficial physiologically, for both mother and infant. Oxygen supply to the fetus is decreased because of compression on the inferior vena cava when the mother is lying on her back and a greater amount of oxygen is delivered through the placenta when the mother is upright. For the mother, pushing is generally both easier and less painful when she is upright. In addition, contrary to the popular opinion that the "perineum is difficult to control" when the woman is upright, there is evidence that less perineal tearing occurs when the woman is in the upright position due to the natural curve of the pelvis, resulting in a different application of the fetal head against the perineum.

The practice of having women remain in the supine position during labor and delivery can actually contribute to both fetal anoxia (and therefore distress) and prolonged labor. To quote Dr. Caldeyro-Barcia, Director of the Latin American Center for Perinatology, WHO, *"Except for being hanged by the feet, the supine position is the worst conceivable position for labor and delivery."*

In recent years, MOH TBA training manuals have stated that the woman should give birth in the position she feels most comfortable. However, all illustrations show the mother delivering in the supine position (flat on her back). The almost universal belief appears to be that lying down is the superior position for birth and the vast majority of health personnel and TBAs interviewed clearly stated that the supine position was preferable over the upright during labor and delivery, reflecting the impact of MOH training over the last 20 years.

Given the fact that the majority of TBAs deliver their mothers in remote and isolated areas, where transfer to the health post center or hospital for complications such as prolonged labor/fetal distress is extremely difficult at best, the traditional upright position for labor and delivery should be actively taught and encouraged during training programs.

Cord Cutting and Care

In Guatemala, the traditional method of cutting the cord has been to sever it with a hot blade (often a machete) or candle. Sometimes hot wax is applied to the stump.

These practices in effect, "cauterize" the cord, leaving it sterile and dry. This traditional practice is one which is "medically" sound, and particularly suitable in an environment where hygiene is minimal and difficult to maintain. Gonzalez and Behar observed in 1966 that neonatal tetanus was rare in certain areas of Guatemala because of the traditional practice of cauterizing the cord and applying hot candle wax.

The TBA training programs have actively discouraged the traditional practice of cauterizing the cord and TBAs are taught instead to cut the cord with scissors, which they are supposed to boil first for 20 minutes. All health personnel and TBAs interviewed stated that the cord should be cut with scissors and not cauterized, although a few TBAs when pressed, stated that sometimes *"the mothers insist that the cord be burned, so I do it."*

Empirical evidence raises very serious doubts about the assumption that even trained TBAs are sterilizing their scissors adequately. In fact, it is the general impression of those who work closely with TBAs that few TBAs clean their scissors properly, let alone boil them regularly for the required 20 minutes before using them to cut the umbilical cord. Several physicians, from different areas, who currently work with TBAs, cited an increase in the incidence of neonatal tetanus in some areas after TBA training courses were conducted, suggesting that replacing the traditional practice of cauterizing the cord with scissors may actually have increased neonatal mortality.

For a variety of reasons, which may include: the tradition of using a hot blade or candle to cut the cord, the general lack of an easily accessible water supply, the expense and shortage of fuel and minimal hygiene in the homes in which most TBAs attend deliveries, it seems unrealistic to expect that the majority of TBAs will routinely "sterilize" their scissors, no matter how much it is emphasized during training. The safest and most practical solution to this problem is to re-introduce the traditional practice of routinely cauterizing the cord with a candle. In addition, serious consideration should be given to other alternatives such as the use of disposable razor blades.

External Version

Traditionally, one of the most important skills of the TBA in Guatemala has been to determine the position of the fetus prior to delivery and to correct the position if it was not "head first" (in the cephalic position). This was accomplished by firmly "massaging" the fetus into the head first position, a practice called external version by the medical profession.

External version, used to turn fetuses from the breech or transverse to the cephalic position, was common medical practice up until the time when cesarean sections became "safer" and readily available, with the advent of antibiotics and improved technology. In the absence of easily accessible operative facilities, external version was far safer than delivering a fetus in the breech position and absolutely lifesaving in the case of a fetus in the transverse position, which always resulted in the death of the fetus and occasionally, the mother as well. With the steady increase in the number of cesarean

sections performed, the practice of external version was condemned by the medical profession as being "unsafe" and the "art" was essentially lost. In fact, some studies have shown external version to be an effective and safe technique, particularly if it is performed before the last month of pregnancy.

The practice of external version has been universally condemned in the TBA training courses and the TBAs have been taught that it is dangerous, with the alternative being that all mothers who have fetuses in the breech or transverse positions should be referred for delivery in the hospital, with the probability of an operative delivery. There are a number of problems with this approach:

1. In all probability, it may be safer in many circumstances for TBAs to attempt external version than simply referring all breeches and transverse positions to the hospital.
2. Many of the areas where the TBAs practice are extremely remote (often hours away from medical backup) and transportation to the nearest health post or hospital is usually difficult and expensive. Transporting a mother in labor to the nearest hospital is often a major problem for the family.
3. Fear of operations of any kind are very strong in the rural population. It is believed that the wound from an operation never completely "heals", rendering the person's body "damaged" in a permanent way. Also, many Mayan women associate operative delivery with sterilization and even death. Operative delivery, in the best of circumstances, does carry with it a significantly higher mortality rate than vaginal delivery.

The practice of universally condemning external version in the TBA training courses should be re-evaluated, particularly in remote areas, where access to medical care is limited.

d. NEUTRAL, OR POSSIBLY BENEFICIAL TRADITIONAL PRACTICES THE TBA TRAINING COURSES OFTEN ADDRESS, WHICH DESERVE A RE-EVALUATION IN TRAINING APPROACH

Temascal (sauna or sweat bath)

In many areas of Guatemala the "temascal" is used during pregnancy and after birth. Customs involving its use vary from area to area and sometimes the infant is also placed inside the temascal for a short period of time. Particularly in the highland areas, where the climate is often cold, the temascal is an efficient and enjoyable method of cleaning and warming the body at the same time. It also serves to effectively relax muscles which are tired and sore from heavy labor or work and to promote circulation.

It appears from interviews with health professionals and reviewing the documents, that the use of the temascal has often been discouraged during TBA training courses. While

it may be advisable to caution TBAs that mothers and especially infants, should not be placed inside the temascal for long periods of time, there seems to be little scientific justification to discourage this practical and soothing custom altogether.

Use of Medicinal Herbs

The tradition of the use of medicinal herbs is strong in Guatemala, as in most indigenous cultures. Herbal remedies are a readily available, effective and inexpensive method for treating many health problems, including those common in pregnancy. Camonile (manzanilla) is known for its relaxant and soothing properties. Mint (hierbabuena) is known for its effectiveness in curing indigestion and clearing respiratory passages. Ginger is an effective cure for nausea. Parsley (perijil) and watercress (berros) are high in iron and effective for treating anemia, as well as being natural diuretics. Although some herbs are known to be toxic in large quantities, for example, pennyroyal (poleo), most are beneficial rather than harmful.

The use of medicinal herbs appears to have been actively discouraged in the TBA training programs and most TBAs interviewed denied using them in their practice. This blanket condemnation of the use of herbal medicine not only seems without merit, but it may be depriving many mothers of safe, effective and inexpensive remedies for common discomforts of pregnancy.

Massage

In some areas it is a traditional practice for TBAs to massage the mother during pregnancy and/or after delivery. In some training courses this practice is discouraged and TBAs are told that it is harmful. There is little or no scientific evidence that even firm massage in pregnancy leads to increased morbidity/mortality. This practice deserves a re-evaluation in training approach.

Shaving of the Perineum

The consultants observed in several of the training manuals that the TBAs were being taught to shave the mother's perineum in preparation for delivery. This hospital based practice, which came to be accepted in many Western countries on the theory that it decreased the incidence of infection, has since been proven to have no positive benefit whatsoever. In fact, some of the studies which were done showed a greater incidence of infection among women who were shaved and all showed a significant increase in discomfort for the women who were subjected to this practice.

The shaving of the perineum for delivery has no valid place even in the institutional setting, and should not be taught in any TBA training program.

e. NEW TBA PRACTICES WHICH WARRANT SERIOUS PROGRAM AND TRAINING INPUTS

The Use of IM Oxytocin in Labor

As discussed in the section on labor and delivery above, the very harmful practice of injecting laboring women with oxytocin intramuscularly appears to be widespread in many areas.

The demand for the use of oxytocin in labor comes from the belief that it shortens labor, resulting in faster delivery of the infant. Physiologically, oxytocin does stimulate uterine contractions, increasing their strength and the length of time that the uterine muscle remains contracted. The dangers with the use of oxytocin in labor, (even under the most controlled conditions in a hospital setting), are: fetal hypoxia (lack of oxygen) and uterine rupture. Both of these conditions are caused by over stimulation of the uterine muscle, causing prolonged contractions, which are too powerful for the normal uterus to withstand. Fetal hypoxia leads to permanent brain damage and often death for the fetus, uterine rupture leads to internal hemorrhage and almost certain death for the mother. The INCAP study mentioned above found a very strong and positive correlation between stillbirth and the use of oxytocin during labor.

In some areas, where the working relationship between health personnel and TBAs is a close one (generally one of mutual respect and support), the practice of giving oxytocin in labor has been minimized. Health personnel in the San Marcos area stated that the practice used to be a problem in their area, but they stopped it by threatening the pharmacists who were selling IM oxytocin to people in the community.

The use of oxytocin during labor, which certainly results in significantly increased morbidity and mortality for both mothers and infants, deserves serious attention. Approaches to solving the problem will probably only be effective if both areas of supply and demand are targeted. Health education on the dangers of using oxytocin in labor needs to be conducted in the community. Strong pressure/penalties should be brought against pharmacists who are selling it (and the drug suppliers/manufacturers who supply it) and a creative and effective teaching component on the side effects of oxytocin should be incorporated into TBA training and in-service programs.

f. OTHER

Delivery Kits

Traditionally in Guatemala, TBAs have been rewarded upon completion of their training with a UNICEF delivery kit. The appearance and contents of the kit has varied over the years.

There are a number of serious problems with the kits which need to be addressed:

1. It has been impossible for the MOH to obtain and distribute an adequate supply of the kits to areas conducting TBA training. Lack of sufficient kits was a universal complaint in all areas visited. Many area staff stated that since the TBAs "expect" kits as a reward for completing the training, they become upset when they don't receive them.
2. The kits appear to have become virtually synonymous with "training" to the point where many MOH personnel expressed the opinion that TBA training could not be conducted without them. The use of the kits seems to have become a major focus of TBA training in many areas, despite strong empirical evidence that few TBAs actually use the kits properly after training (if at all). A significant proportion of the MOH Manual for TBA Trainers is devoted to the kit.
3. Many health workers and other observers in the community state that the TBAs do not use their kits. The consultants themselves observed a number of kits covered with dust on shelves in the TBAs homes. Interviewees stated that many TBAs were "embarrassed" to be seen with the kits and that people in the community did not like the TBAs to use them.
4. The contents of the kits are not necessarily appropriate/useful for TBA attended deliveries in Guatemala. For example, scales are included in many of the UNICEF kits but not only are the measurements inappropriate for Guatemala (kilos instead of lbs), most of the TBAs are not able to use them correctly. One physician stated that all newborns in his area weighed "7 lbs" because although they were weighed with the scales, the TBAs couldn't read them. Also, several health workers complained that the contents of the kits had decreased to the point that there was "too little" inside them now (eg; insufficient cloth to make clean rags with).
5. Empirical evidence strongly suggests that of the TBAs who do use their kits, most do not use the contents properly (ie; they do not boil the basins or scissors), often to the serious detriment of the health of the mothers and babies they are attending. Having the kits and using them incorrectly (which appears to be the norm), may in fact lead to higher morbidity and mortality than if there were no kits at all. Medical personnel in some areas reported an apparent relationship between the introduction of UNICEF kits and an increase in cases of neonatal tetanus.

Definition of High Risk

In general, the standard WHO recommendations that women in certain categories be referred to the hospital for delivery have been followed in the training programs. Some of the categories, such as the referral of twins, breeches and transverse lie, are clearly

appropriate. However, some of the recommendations are unrealistic and inappropriate for the current situation in Guatemala and need to be re-evaluated. For example, there is little justification/evidence that the blanket recommendation that all primigravidas and multigravidas be referred for hospital delivery is appropriate/realistic, given the fears of hospitalization and the geographical, transportation and medical back-up situation in Guatemala. Advocating practices that are unnecessary/unrealistic fosters lack of credibility in the TBAs/community and decreases the probability that critical cases (such as transverse lie) will be referred for medical intervention.

B. Expanded Role

The 1988 MOH/MCH report on TBA Training and In-service Activities states that one of its four major objectives is, *"For TBAs to educate members of the community on priority maternal/child health problems that have been identified by the MOH, and for TBAs to carry out interventions to reduce these problems."*

Two recent studies show that the TBA is a well-known and respected member of the community. Preliminary results of the AGES survey, conducted in 1988 in 6 indigenous villages found: that the TBA was often mentioned as the person they thought could best teach natural family planning and care of mothers and infants; and the TBA was the person one should turn to if there were problems during a delivery. The INCAP KAP Survey found that over 80% of mothers know who the closest TBA is and that over 80% of mothers have had a TBA visit their home during the past year. This shows a contact rate with mothers that is 4 times higher than that of any other health worker.

TBAs are an already established cadre of health "volunteers" performing a significant service in the communities in which they live. They are paid little, if anything for their services. Their advice on matters, especially related to maternal health, is usually respected. Unlike other community based health workers/volunteers, which are artificially created, TBAs have already been "chosen" by families in the community.

In a number of developing countries TBAs are utilized successfully in an expanded role to promote health education and to carry out child survival activities in the community. In Guatemala, a number of health professionals stated that TBAs had made significant contributions in their areas in promoting vaccinations and participating in the vaccination campaign. In general however, TBAs in Guatemala have not been actively utilized in an expanded role. Some reasons for this include:

1. TBAs in most areas do not have a close working relationship with professional health staff.
2. Many TBAs live in remote areas, do not speak Spanish, are illiterate and elderly and therefore considered "difficult to train."

3. TBAs are generally accustomed to working in isolation and traditionally see themselves in a very narrowly defined role (birth), not as a part of a larger system. This is not the case in many other countries, where TBAs are "healers", often treating entire families for a variety of illnesses.

The potential for an expanded role for TBAs in child survival/health promotion/health education activities in Guatemala is real, however some basic prerequisites need to be met before this potential can be realized. These include: an improved relationship with the formal health care system; improved attitudes towards TBAs and greater recognition of their importance in the health care system by health professionals; significantly improved training materials/methodologies/programs and an improved system for supervision in the rural areas. For the foreseeable future, role expansion for TBAs will probably be more successful if it continues in the direction of ORT, immunization and basic health promotion.

TBA training programs should continue to include information about the importance of child spacing for child survival, education about family spacing methods and encourage TBAs to refer mothers for services. However, due to a number of cultural factors and the general situation with TBAs, it would probably be unwise, counter productive and unrealistic and to attempt to involve them actively in family planning interventions at this time.

C. Administrative Constraints

1. Supervision

Leedam, in her study of Traditional Birth Attendants, noted "*...the institutions which claim success usually have good supervision, by enthusiastic health workers who are supportive of the TBAs. Almost invariably the studies which show negative results cite as the major cause for failure lack of supervision.*" One of the prominent features of the very successful PVO programs mentioned above is the very existence of this enthusiastic, supportive supervision. The majority of TBAs practice in remote rural areas which makes supervision problematic. It is time-consuming and often expensive for the TBA to travel to the nearest health post and there is usually little incentive for her to do so. MOH health staff generally lack adequate resources, transportation and time to carry out supervisory activities. The monthly meetings with TBAs which are supposed to be conducted at all the health posts for the purposes of supervision, in-service education and reporting of births/high risk cases, often do not take place or are not well-attended by the TBAs.

If the importance of working with TBAs is seen as a means for impacting on maternal child mortality, as it rightly should, then the TBAs actions are only one half of the equation, the other half being the institutional response to the TBA referral. To our knowledge, no one has studied that response, although the section on incentives and disincentives for referral above identifies a number of serious problems with it. Supervision of MOH management of high risk cases is also absent.

2. Monitoring.

Consistent, on-going monitoring is one of the most effective tools in the implementation and management of any program. Ideally, monitoring should be seen as an integral part of any program efforts and effective mechanisms to insure that the impact of interventions are measured are usually critical to the achievement of program goals. Performance indicators, which permit the opportune identification of problems, need to be established.

3. Evaluation.

Despite almost 30 years of training by the MOH, to the consultants' knowledge no one has conducted an evaluation on the impact the training has had on TBA practice or on maternal/infant mortality and morbidity in spite of the fact that evaluation is consistently mentioned in Ministry training documents. This lack of evaluation is a critical gap in all of the training programs.

4. Financing.

All MOH TBA training is administered from the central level. There appear to be a number of significant problems at the management level related to the implementation of TBA training. A universal complaint from the areas was that they were not able to plan for training because they never knew when the funds were going to be available. Funding, when it was available, was usually distributed on extremely short notice and at inconvenient times (holiday season when most staff were away). However, because the areas are required to spend funding almost immediately, most TBA training takes place on very short notice, with little time available for necessary program development/planning. In addition, although the MOH dictated that a certain number of TBAs in a given area be trained, funding and materials were available for only a small percentage of that number. A common complaint was that the TBAs did not receive even their promised daily expense stipend or delivery kits.

IV. MAJOR FINDINGS

1. The TBA is the major provider of health care for women in Guatemala. She delivers at least 60% of all babies in the country, over 90% in some areas, and is the primary provider of prenatal care. As mortality from diarrheal and other infectious diseases declines in response to current child survival programs, a much larger portion of infant mortality will be seen in the neonatal period (as in Ecuador, for example), where improved prenatal and delivery care can have a significant impact. The GOG recognizes that because of its limited capacity, both now and in the foreseeable future, the traditional midwife will continue to be the

prime provider of obstetric care. *Despite the significant role that the TBA plays in the delivery of health care services, in general:*

- The TBA receives little recognition and support for her contribution to the health care system in Guatemala.
 - The TBA is not seen as a part of the health care team.
2. Inadequate attention has been paid to the training of effective trainers of TBAs. In general, the training courses do not use innovative, effective and appropriate educational methodologies. There is a lack of effective training tools and materials. Much of the training content is ethnocentric, institutional based, inaccurate and inappropriate for childbirth in the community.
 3. There has been a total lack of investigation/evaluation of actual TBA practices, their impact on maternal/infant mortality and morbidity and the impact TBA training has had on improving MCH outcomes.
 4. There are several very exciting TBA initiatives currently underway in Guatemala, one of the most significant being conducted by Dr. Barbara Schieber at INCAP in the Quetzaltenango area, with technical assistance from Dr. Al Bartlett. This small project is the most systematic and comprehensive look at the knowledge, attitudes and practices of TBAs, mothers and fathers and the present response of the referral system to the TBAs and their patients, ever carried out in Guatemala. Any development of future TBA programs should take full advantage of this excellent project. The consultants are aware of several vital areas of Dr. Schieber's investigation for which funding is not currently available. These include: investigating each case of maternal mortality to better delineate the true causes and the development and implementation of a model TBA training program with the priority being the improvement of both TBA high risk case identification and referral and the MOH's actual response to those referrals.

Another creative initiative is the one being funded by UNICEF in the Huehuetenango area, in a collaborative effort between the Maryknoll Mission in Jacaltenango and the MOH health district of San Antonio Huista. This will be the first organized effort by the MOH to find a common ground upon which a TBA training program can be built, which incorporates a full appreciation of traditional practices and beliefs and an appropriate utilization of modern techniques.

The University of Francisco Marroquin has also developed an impressive community health program, in which the TBA plays an integral part. This program is replicable and could be expanded into additional areas of the country by other medical schools, through the MOH or other NGOs.

V. RECOMMENDATIONS

Given the lack of response to previous evaluations of the situation regarding TBAs in Guatemala, most of which have had excellent observations and recommendations (summarized in Annex G), the consultants believe that it is critical to view this document as one step in a process of change in this area, so vital to maternal/child health in Guatemala. The consultants strongly recommend that USAID give adequate attention to the continuation of this process, in collaboration with other agencies such as INCAP, UNICEF, PAHO, and UNFPA.

We recommend that the next stage in the process of achieving the maximum potential of the TBA in promoting better care for mothers and infants in Guatemala be the implementation of a national workshop/seminar. This is an opportunity for Guatemala to go to the forefront in the development of strategies in the Safe Motherhood/Maternal Child Health and Nutrition Initiatives. The goal of the workshop would be to bring together a working group of experts and professionals involved in TBA program design and implementation to: review appropriate prenatal and birthing practices, training methodologies and content; and to develop strategies for improving administrative support systems including supervision, program monitoring, evaluation, referral and logistical/financial support. Some or all portions of the workshop would be attended by: the Ob/Gyn Medical Society, the Ob/Gyn faculty of the medical and nursing schools, the faculty responsible for the medical school rural field experience, the MCH Division of the MOH, area health chiefs and nurses, the PVOs involved in TBA programs, and donor organizations supporting TBA activities.

Obtaining co-sponsorship of the workshop with other donors would maximize its potential impact for revolutionizing the relationship between the traditional and modern maternal child health care systems to the benefit of the women and children of Guatemala. A suggested title for the workshop is "*Respecting Diversity* (cultural beliefs and practices), *Finding Common Ground*" (the improved health of mothers and infants). The workshop should be seen as a mechanism for achieving the recommendations detailed below.

For the purposes of discussion, we have divided the recommendations into 6 target areas:

1. Institutional Development
2. Training
3. Health Education
4. Inter-Agency Coordination
5. Research/Evaluation

6. Other

A. INSTITUTIONAL DEVELOPMENT

1. A training course in working with the community should be developed and incorporated into the pre-service training programs for all physicians and nurses.

The course content should include:

- In-depth information on the number of TBAs in Guatemala and their important role/contribution in the provision of health care to the population of Guatemala (eg; TBAs deliver the majority of babies and provide most of the prenatal care).
- Education on general skills and services provided by TBAs, with emphasis on the fact that the role and performance of certain skills will necessarily vary depending on the community's distance from health services, geographical and transportation difficulties, etc.
- Emphasis on the importance of respecting cultural practices and belief systems when working with TBAs. For example, respect and sensitivity for indigenous women's need for protection of extreme modesty.
- The importance of community outreach. For example: understanding the concept that "the hospital/health post is NOT the community"; methods for building relationships/support with community leaders.
- Training in effective communication and supervision skills. For example: positive reinforcement instead of scolding to achieve desired modifications in behavior/practices; the importance of including TBAs directly in the care of patients which they refer to the health post/hospital (collaboration and demonstration) whenever possible.
- The development of an awareness that; "Western medicine" is simply one of many health disciplines and is not necessarily the "best" or only effective methodology for treating health conditions; institutional routines/practices are often not appropriate nor feasible to implement in the community setting and in fact, they may even cause severe harm when they replace traditional practices (eg; using scissors, which are difficult to sterilize properly, to cut the umbilical cord instead of cauterizing it). Condemning and discouraging traditional practices, without offering a reasonable alternative (eg; external version in areas where health services are inaccessible) is a disservice to the community and fosters lack of confidence in the health care system.

- Appropriate experience in the community with TBAs should be provided if possible, as is being done at the Francisco Marroquin University Medical School program.
2. An in-service education program in working with TBAs should be developed and conducted for all MOH personnel, using the guidelines outlined in recommendation #1.
 3. Mechanisms to improve the supervision and monitoring of both TBA practice and training impact on practices need to be improved. For example, the development of priority indicators which monitor TBA practice such as the number and type of cases referred.
 4. The impact of TBA referral on reducing maternal/infant mortality depends on the appropriateness of the treatment of high risk cases by the health care system. Recommendations for improving the high risk referral system include:
 - Mechanisms to monitor MOH response to TBA referrals should be developed (eg; outcome indicators).
 - The MOH norms for high risk should be analyzed and re-defined (eg; recommendations for all women having their first babies delivering in the hospital).
 - Priorities for high risk referral and care should be developed based on major causes of maternal/child morbidity and mortality (eg; transverse lie).
 - The development of peer review committees to regularly review high risk case outcomes/management in each area should be a priority. Dr. Al Bartlett at INCAP, who is both a perinatologist and an epidemiologist with extensive public health field experience, could provide technical assistance in coordinating this effort.

B. TRAINING

1. The TBA training course content should be re-evaluated and revised. This should include:
 - A current review of the literature regarding "safe" obstetrical practice (eg; the safest position for delivery, safety of external version, etc.)
 - The content of the training course should be reduced and prioritized.
 - The course content needs to be re-evaluated in terms of: the setting in which the TBA practices; realistic expectations for change in practice taking cultural belief systems into account and the resources available to the TBA.

- It is not necessarily feasible nor desirable to transfer institutional routines/practices to the community setting. All procedures taught in the course should be evaluated with this fact in mind.
 - Abstract concepts should be eliminated from course content as much as possible. Content should be redesigned to relate the practices/advice/behaviors being taught to the TBAs belief system and daily life. "Storytelling" as a methodology for teaching and reinforcing course content should be used extensively in the training program.
 - Any new course/content should be tested and evaluated in a pilot program before it is implemented on a national scale.
2. The length and timing of the TBA training course should be modified. The training would probably be significantly more effective if it were given in a series of shorter (eg; 1-5 days), regular sessions over a period of time (eg; 6 mos. to 1 year). The current MOH course length has a number of disadvantages which include:
- The TBAs are away from their homes/work for an extended period of time.
 - The trainers are away from their usual work responsibilities for an extended period.
 - The TBAs' absorptive capacity to acquire new knowledge and skills at one time is limited.
 - It is difficult to maintain energy, interest and enthusiasm for course content on the part of both the TBAs and the trainers for 15 consecutive days.
3. The MOH TBA Training Manual for both trainers and TBAs should be revised. The revision of the manual should include, among other things, drawings of mothers giving birth in upright positions. The ASECSA Manual for TBA training is culturally appropriate and could be used as a model, with modifications. Field testing and validation of the redesigned manual should be carried out prior to publishing it. Adequate numbers of the new manuals should be published and distributed to all personnel involved in TBA training.
4. Effective, in-expensive, locally made tools and materials for TBA training (eg; models for demonstration, large culturally appropriate flip charts) should be developed. These materials should be produced and distributed in adequate amounts to all health staff involved in TBA supervision and training.

5. An in-service training program to train trainers of TBAs should be developed and given to all health personnel involved in TBA training. The program should include, for example: training in teaching persons with little or no education, innovative participatory training methodologies such as games and role playing and training in adapting teaching content to relate to cultural belief systems.

6. TBAs themselves should be responsible for conducting as much of the training as possible, in collaboration with health personnel. This has been a successful technique at the Maxena Clinic program in Santo Tomas La Union in Suchitepequez. Other effective innovative techniques, such as including TBAs' husbands in the training (this has been done successfully in the San Marcos area), should be explored and incorporated into the training programs.

C. HEALTH EDUCATION

1. Program efforts to educate families in the community on safe birthing practices, the dangers of using IM oxytocin, the health benefits of prenatal care and child survival interventions (eg; immunizations, ORT) should be expanded. This could be accomplished by targeting areas served by health posts using community health workers/volunteers, church groups, mothers groups, medical and nursing staff/students. Health education activities could be coordinated and expanded through the PVOs.

2. The feasibility of using social marketing (eg; HealthCom) to promote education in the areas mentioned above should be evaluated.

D. INTER-AGENCY COORDINATION

1. Efforts should be made to improve inter-agency coordination in the development and implementation of TBA initiatives. Resource and information sharing could be improved by the formation of a working committee with representatives from all organizations involved in TBA activities. The TBA workshop could be an effective forum for beginning the process of improving inter-agency communication.

2. The formation of a national midwife association should be explored.

3. USAID should consider supporting the creation of a national PVO which would be responsible for the coordination of TBA activities.

E. RESEARCH/EVALUATION

1. The lack of any evaluation on the effectiveness and impact of TBA training has been a major gap. Evaluation and monitoring of TBA training and supervision should be an integral part of any future training activities.

2. Increased research should be supported in the following areas:

- TBA practices in the community and their relationship to maternal/infant mortality and morbidity.
- The major causes of maternal/infant mortality and morbidity in Guatemala, with an emphasis on the neonatal and perinatal periods.
- The relationship of prenatal care with improved outcomes (what specific prenatal interventions and why).
- The impact of TBA training on changes in practice and maternal/infant mortality and morbidity.
- An evaluation of the standard protocols and medical management of high risk cases.

3. USAID should consider increased support for Dr. Barbara Schieber's project in Quetzaltenango and a follow-on project to Dr. Al Bartlett's study. These projects have the potential to impact significantly on the reduction of maternal/infant mortality and morbidity in Guatemala.

4. Further investigation of TBA practices in the Ladino community should be considered.

E. OTHER

1. The UNICEF delivery kits should be replaced with a locally made alternative. This is discussed in depth in section 5 f. of the document.

2. Methods for stopping the sale of IM oxytocin in pharmacies should be explored on both the local and national level. The sale of this drug appears to be increasing and its inappropriate use constitutes a grave danger to the health of mothers and infants in Guatemala.

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ATTACHMENT I
 PIO/T No. 520-0000.5-3-80234

SCOPE OF WORK

I. Objective

To provide USAID/Guatemala with a "state-of-the-art" assessment of community-based health workers (CBHW) and in particular, the traditional birth attendant (TBA), and their potential use in health care delivery programs.

II. Background

Guatemala has a remarkably rich experience with CBHW's including the program of Rural Health Technicians (Técnicos de Salud Rural) which is unique to Guatemala, rural health promoters, volunteers of various descriptions, traditional birth attendants, traditional healers, patent medicine salesmen and the paid auxiliary nurse who works at the lowest level of the official health system, the Health Post. There have been several operational research efforts to test the usefulness of various approaches to health care delivery using this level of worker, notably SINAPS, PRINAPS and the "Patulul Project." Some very interesting studies and evaluations have been carried out of isolated dimensions of the work of some of the CBHW's, including a recent look at the effectiveness of patent medicine salesmen (PMS) in communicating child survival and family planning messages to the semi-literate, traditional rural population of Guatemala.

As an AID "Child Survival Emphasis Country", Guatemala will continue to receive financing for assistance in improving health status in general, and of children under five years of age in particular. Most recently, USAID approved a three-year extension to the family planning program, which included tentative earmarking of funds for developing activities in the Ministry of Health which revolve around reducing risks involved in the birth process. A key figure in this program is expected to be the traditional birth attendant (TBA).

CONTINUATION SHEET	UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY AGENCY FOR INTERNATIONAL DEVELOPMENT	<input type="checkbox"/> Worksheet <input checked="" type="checkbox"/> Summary	PAGE <u>2</u> OF <u>6</u> PAGES
	<input type="checkbox"/> PTO/C <input type="checkbox"/> PTO/P <input checked="" type="checkbox"/> PTO/T <input type="checkbox"/> PA/PZ	1. Cooperating Country Guatemala	
		2a. PTO Number 520-0000.5-3-80234	2b. Amended <input checked="" type="checkbox"/> Original OR No. _____
	3. Project Number and Title PROGRAM DEVELOPMENT AND SUPPORT (POPULATION) 520-000.5		
Indicate block numbers	Use this form to complete the information required in any block of a PTO/P, PTO/T or PA/PZ. For PTO/C, furnish the item number, quantity, description/provisions, including catalog stock number and price when available.		

Quoting from the Project Paper Supplement:

"Reducing reproductive risk is a priority for this component. Worldwide, mortality risks for mother and child are highest after four births, when births are spaced less than two years apart, or when the mother is under age 18 or over 35. High parity and inadequate spacing interact synergistically to increase risk. All of these factors are common in Guatemala.

The MOH recognizes that the TBA's provide the majority of pre-natal and delivery care in Guatemala, but that training and minimal equipment are required to improve delivery techniques and for the detection and referral of high risk pregnancies.

The nature and extent of MOH activity financed by the Project in the area of training of TBA's will be determined by a careful, "state-of-the-art" study of existing knowledge and experience in this area in Guatemala. The study to be financed from non-Project funds, will take place in the Fall of 1988 and will lay the basis for preparing and scheduling MOH training activities, as well as further studies to be undertaken by AGES (another agency receiving financial assistance under the family planning project). Tentatively, the overall plan includes: 900 auxiliary nurses trained in reproductive risk management, and equipped with appropriate training materials and TBA kits. These auxiliary nurses, in turn, will identify and train an average of four TBA's each in basic principles of asepsis, the use of the kits, and detection and referral of high risk pregnancies and improved pre-and post-natal maternal health care. In order to effectively reduce maternal risk while establishing an on-going relationship between the auxiliary nurse and the TBA, the Project will coordinate with UNEPA in the provision of iron supplements for distribution by the auxiliary nurses through the TBA's to their patients. These incentives, combined with progressive improvements in the MOH reproductive health referral system, significantly enhance the probability of success in this outreach effort.

Although contraceptive distribution is not expected to form an

SITUATION: SHEET	UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY AGENCY FOR INTERNATIONAL DEVELOPMENT	<input type="checkbox"/> Worksheet <input checked="" type="checkbox"/> Invoice	PAGE 3 OF 6 PAGES
	<input type="checkbox"/> PIO/C	1. Cooperating Country Guatemala	
	<input type="checkbox"/> PIO/P	2a. PIO Number 520-0000.5-3-80234	2b. Amendment <input checked="" type="checkbox"/> Original OR No. _____
<input checked="" type="checkbox"/> PIO/T	3. Project Number and Title PROGRAM DEVELOPMENT AND SUPPORT (POPULATION) 520-0000.5		
<input type="checkbox"/> PA/PR			

Indicate block
numbers

Use this form to complete the information required in any block of a PIO/P, PIO/T or P.A. PR. For PIO/C, furnish the item number, quantity, description/specifications, including catalog stock number and price when available.

important part of the TBA's activities, the improved relationship between the formal and informal health sector should lead to greater awareness of contraceptive alternatives and their availability at different levels of MOH facilities."

Thus, the TBA would seem to be an important potential resource for delivering health services to mothers and their children, in culturally acceptable and cost-efficient ways. The study financed by funds earmarked by this PIO/T will attempt to analyze the aggregate experience with TBA's and gather the information into one document which will assist USAID/Guatemala in structuring assistance to this element of the health sector.

II. Specific Tasks

1. Carry out information gathering (includes literature searches, interviews of key informants, document reviews, interview of TBA's themselves, other donors, etc.) which leads to a definition of the scope and magnitude of the TBA human resources in Guatemala. Questions such as the following will be addressed:

- a. Describe in detail their practice of midwifery in the community.
- b. How many are there and where are they located?
- c. Are there significant differences in the practice of midwifery among spanish speaking midwives and mayan speakers?
- d. What kinds of health tasks, in addition to the traditional birth assistance, do they carry out?
- e. Are they paid for the health tasks they perform, in addition to fees they may receive for assisting with the birth process?
- f. How was their recruitment, training and initial outfitting financed, if any?

CONTINUATION SHEET	UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY AGENCY FOR INTERNATIONAL DEVELOPMENT	<input type="checkbox"/> Direct <input checked="" type="checkbox"/> Invoice	Page <u>4</u> OF <u>6</u> PAGES
	<input type="checkbox"/> PIO/C <input type="checkbox"/> PIO/P <input checked="" type="checkbox"/> PIO/T <input type="checkbox"/> PA/PR	1. Cooperating Country Guatemala	2a. PIO Number 520-0000.5-3-80234
Indicate block numbers	Use this form to complete the information required in any block of a PIO/P, PIO/T or PA/PR. For PIO/C, furnish the item number, quantity, description/specifications, including catalog stock number and price when available.		

2. Through the information gathering activities in (1) above, address the following issues:

a. Effectiveness: How effective are TBA's at what they do? Are there areas that TBA's are less effective (by their own admission or generally accepted)? Are TBA's relatively more effective in some tasks than other "health change agents" in the community, ie. promoters, TSR's, pharmacists? Which health tasks?

Can the TBA bridge the alleged "cultural barriers to acceptance of health services" any more effectively than other health workers?

b. Competition: To what degree is there specialization among traditional health practitioners in the Guatemalan community in terms of care of the newborn through the first year of life? Does the degree of specialization reach a point of frank competition? Would competition be the result if TBA's received training on "care of the newborn and the infant?" Competition with which "health change agents?"

c. Voluntarism: Is it reasonable to expect TBA's to devote significant amounts of time, outside of earning their fees for assisting in the birth process, in providing assistance, advice to mothers regarding the health of their newborn and infants?

d. Incentives: Would the TBA view referral of "high risk births" to hospital or health centers as a disincentive to participate in the MOH program, ie. lose a client to the formal health system? Is there any reason to believe that TBA's would accept MOH's assertion that the system would "counter refer" normal deliveries from hospital to the TBA?

3. Discuss the relative advantages and disadvantages (technical, socio-economic, cognitive, geographic, etc.) of involving the TBA in delivering some or all the child survival interventions, including birth spacing, in Guatemala. (This discussion should cite empirical data wherever possible.)

CONTINUATION SHEET	UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY AGENCY FOR INTERNATIONAL DEVELOPMENT	<input type="checkbox"/> Worksheet <input checked="" type="checkbox"/> Invoice	PAGE <u>5</u> OF <u>6</u> PAGES
	<input type="checkbox"/> PIO/C <input type="checkbox"/> PIO/P <input checked="" type="checkbox"/> PIO/T <input type="checkbox"/> PA/PR	1. Cooperating Country Guatemala	
		2a. PIO Number 520-0000.5-3-80234	2b. Amendment <input checked="" type="checkbox"/> Original OR No. _____
Indicate block numbers	3. Project Number and Title PROGRAM DEVELOPMENT AND SUPPORT (POPULATION) 520-0000.5		
	Use this form to complete the information required in any block of a PIO/P, PIO/T or PA/PR. For PIO/C, furnish the item number, quantity, description/specifications, including catalog stock number and price when available.		

4. Review critically the experience of public, private and PVO's in the training, employment, supervision of TBA's. The review should comment on political and social advisability of USAID support of these agencies in activities with the TBA.

5. Present a set of recommendations to USAID which will guide decisions regarding resource allocation to activities which promote involvement of TBA's in the Guatemalan health system.

These recommendations should be as specific and operational as possible, ie. not "strengthen the training of traditional midwives" and rather, "increase the relative amounts of practical training for midwives in sterile technique for cutting the umbilical cord, using locally available cutting instruments."

The recommendations should clearly delineate the parameters of the risks involved and the necessary prior conditions to taking a decision to fund a particular activity related to the TBA.

III. Level of Effort

This assignment can be accomplished by qualified consultants (as described below) in approximately 84 person-days, over 1-2 calendar months with 6-day workweeks authorized.

IV. Qualifications

The incumbents should have qualifications:

A. Chief of Party: Medical degree or advanced degree in Medical Anthropology, Sociology or Public Health (DrPH, PhD, Masters), or related fields. He/she should have experience in the study of implementation of rural outreach health programs, rural community organization, introduction of Innovations in traditional societies, preferably in Latin America. The incumbent should also have FS-3 level or better in Spanish.



- PIO/C
PIO/P
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PA/FR

Indicate Stock numbers

Use this form to complete the information required in any block of a P.I.O. For P.I.O. PIO/S/PA/FR furnish the item number, quantity, description/specifications, including catalog stock number and price when available.

B. Medical Anthropologist: Advanced degree in Medical Anthropology, Sociology or Public Health (DrPH, PhD, Masters), or related fields. He/she should have experience in the study of communications in rural communities, introduction of Innovations in traditional societies, preferably in Latin America. Direct experience in studying the role, function and activities of TBA's in Latin America is highly desirable. The incumbent should also have FS-3 level or better in Spanish.

C. Trainer: Advanced degree in Education, Sociology or Public Health (DrPH, PhD, Masters), or related fields. He/she should have experience in the design, implementation and evaluation of training programs for community based health workers destined for work in rural communities, preferably in Latin America. The incumbent should also have FS-3 level or better in Spanish.

V. Term of Performance -

The assignment should be carried out during the period September-October 1988.

APPENDIX B

SCHEDULE AND LIST OF CONTACTS

Monday, January 16

8am Met with Jayne Lyons, Population Liasion, USAID

Tuesday, January 17

10am Met with Jayne Lyons, Population Liasion and John Massey, Health and Population Officer,USAID

11am Met with Dr. Al Bartlett, Epidemiologist, Institute of Nutrition and Health for Central America and Panama (INCAP)

1pm Met with Dr. Hernan Delgado, Director of Nutrition Division, INCAP

2pm Met with Dr. Adan Montes, MCH Advisor/INCAP

2:30pm Met with Dr. Maria Elena Claros, Educator, INCAP

Wednesday, January 18

8am Met with Jayne Lyons, Population Liasion and John Massey, Health and Population Officer,USAID

2pm Met with Eugenia de Monterosa, Director of Asociacion Guatemalteca de Educacion Sexual (AGES)

Thursday, January 19

10am Met with Miriam de Figueroa, Assistant Program Officer, UNICEF

11am Met with Cristina Martinez, Division de Recursos Humanos MSP

Friday, January 20

9am Met with Dr. Elena Hurtado, Anthropologist, INCAP

2pm Met with Dr. Barbara Schieber, Research Epidemiologist, INCAP

4:30 pm Met with Hedi Deman, Human Resources Division, INCAP

Saturday, January 21

4pm Met with Dr. Barbara Schieber, Research Epidemiologist, INCAP

Sunday, January 22

11am Met with John Massey, Health and Population Officer, USAID

Monday, January 23

10am Met with Dr. Noe Orellana, Dr. Alicia Ruano de La Cruz and Licenciada Marlin Elizabeth Paz Castillo, Division Materno-Infantil (MCH Division), MSP

11:30am Met with Jayne Lyons, Population Liasion and John Massey, Health and Population Officer, USAID

2:30pm Met with Dr. Raul Rosenburg, Director of Family Planning, MOH and John Massey, Health and Population Officer, USAID

Tuesday, January 24

8:30am Field visit with Dr. Al Bartlett to Santa Maria de Jesus, Sacatepequez. Interviewed 3 TBAs, Dr. Carlos Morales, Field Investigator, Dr. Aida Mejicanos, Acting Field Investigator and Elizabeth de Rojo, Promotora.

Wednesday, January 25

Reviewed documents and arranged field visits.

6pm Met with Dr. Johnny Long, Project Hope

Thursday, January 26

8am Field visit to San Juan, Sacatepequez to talk with Dr. Carlos Andrade, Director of Public Health Program, Francisco Marroquin University and observed a meeting with approximately 15 medical students and 55 TBAs from the area. Also visited 2 health posts and a birthing center in the area with Dr. Andrade and a medical student.

Friday, January 27

8:30 Met with Dr. Alfredo Juarez, Director, Asociacion de Servicios Comunitarios de Salud, (ASECSA), in Chimaltenango.

Saturday, January 28

Reviewed documents.

Sunday, January 29

Travel to Panahachel.

Monday, January 30

9am Travel to Santiago Atitlan to meet with Betsy Alexander, Program Coordinator, Project Concern International (PCI) and PCI Team. Met with Dr. Angelica Bixcul, Director of Community Health Program, PCI, Leticia Toj de Mendez, Assistant Director of Community Health Program, PCI, and Betsy Alexander.

Tuesday, January 31

8am Met with Dr. Angelica Bixcul, Leticia Toj de Mendez and interviewed 2 TBAs trained in PCI Program, from different towns, in their homes.

2pm Met with approximately 10 local PCI staff involved in training and community activities in the project area where the TBAs are practicing.

Wednesday, February 1

8am Met with Leticia Toj de Mendez and a young, very active, TBA from the town of Santiago Atitlan.

9:30am Met with Betsy Alexander.

11:30 am Travel to Panahachel.

3pm Met with Dr. Sapon, Jefe Interino de Area, Solola, MSP.

Thursday, February 2

9:30am Met with Dr. Juan Rolando Perez, Jefe de Area, and Silvia Eugenia Blanca, Trabajadora Social, Santa Cruz de Quiche, MSP.

11am Met with Lucio Ernesto Sosa Cox, Enfermero de Distrito and Miriam Blanco, Enfermera Auxiliar, Puesto de Salud, Chicicastenango.

2pm Travel to Quetzaltenango.

Friday, February 3

9:30 am Met with Dr. Jorge Flores, Director, Guillermo Nowell, RN, Field Supervisor and Federico Motta, TSR, Field Supervisor, Project Hope Guatemala.

2:30 pm Met with Dr. Raul Cinchilla Jimenez, Jefe de Area and Licencia Clara Luz Varios, Quetzaltenango.

Saturday, February 4

Field visits in Quetzaltenango area with Dr. Barbara Schieber, and Dr. Carlos Gonzalo Gonzalez, INCAP. Met with 3 TBAs from different areas, in their homes. One TBA had a maternity center, where she attends births, in her home.

Sunday, February 5

Met with Dr. Barbara Schieber and Dr. A. Bartlett, INCAP, in Quetzaltenango.

Monday, February 6

Field visits Quetzaltenango area.

8:30am Met with Dr. Sandra de Leon, Director, and Licencia Berna Leticia Barrios de Gonzalez, Health Post, Ostuncalca

10am Met with Judith Mendez, TSR, Health Post, Chiquirichapa

11am Met with Licencia Maria Honestina Cajas, Health Post, San Martin

3pm Met with Dr. Mark Papania, Child Survival Fellow, Project Hope

Tuesday, February 7

Field visits San Marcos area. Met with Dr. Alma Soemia Chew, Jefe de Area, San Marcos.

7pm Met with Dr. Barbara Schieber in Quetzaltenango.

Wednesday, February 8

8am Travel to Totonicopan.

9:30am Met with Dr. Freddy Gonzales, Jefe de Area and Licencia Carolina de Luna, Enfermera de Area, Totonicopan.

10:30am Travel to Huehuetenango.

2pm Met with Dr. Mario Mazariegos, Jefe de Area and Licencia Leonor Rodriguez, Enfermera de Area and Sandra de Recinos, Enfermera de Distrito, San Pedro Necta, Huehuetenango.

Thursday, February 9

8am Travel to Jacaltenango, with stop in San Antonio Huista.

11am Met with Medico de Distrito and Lcda. Berta de Hernandez, San Antonio Huista.

1pm Met with Sister Jean Roberts, Maryknoll Hospital, Jacaltenango, Huehuetenango.

2:30pm Travel back to Huehuetenango.

Friday, February 10

8am Travel to Santo Tomas Union, Suchitepequez. Met with Dr. Hildebrando Carrillo and Juan Jose Ixcol, Health Promoter, Maxena Clinic.

3pm Travel back to Guatemala City.

Saturday, February 11

Reviewed documents and began report.

Monday, February 13

9am Met with Lcda. Lucrecia Alegria, National Program Officer, UNFPA.

11am Met with Dr. Rene Salgado, Training Advisor, Management Sciences for Health.

2pm Met with Division of MCH, MOH staff.

Tuesday, February 14

11am Field visit to ASECSA in Chimaltenango to meet with Mateo Poz, Director of Preventive Health Programs, Clinica Maxena in Santo Tomas La Union, Suchitepequez.

Report preparation.

Wednesday, February 15

Report preparation.

Thursday, February 16

9am Met with Barbara Jackson, Director of Health and Nutrition Programs, CARE, Guatemala.

Report preparation.

Friday, February 17

10:30 Met with Liliana Ayalde, Chief, Human Resources Division, USAID/Guatemala

12pm Met with Dr. Alberto Viau, Guatemalan Academy of Sciences

Report preparation.

Saturday, February 18

Report preparation.

Sunday, February 19
Report preparation.

Monday, February 20
Report preparation.

2pm Met with Jayne Lyons, USAID. Draft report submitted.

Tuesday, February 21

9am Seminar conducted by consultants for representatives from organizations from throughout country who are working with TBAs. List of participants:

Leticia Toj Umul	PCI
Al Battlett	INCAP
Guillermo Nowell	Project Hope
Eugenia Monterroso	AGES
Gloria Corpin de Hernandez	AGES
Dunia Miranda	AGES
Maria Angelica Bixcul	PCI
Betsy Alexander	PCI
Cristina Martinez	Recursos Humanos
Jayne Lyons	USAID
Eliana Arias	UNICEF
Barbara Schieber	INCAP
Nellie Mendez	MOH/MCH Division
Rene Salgado	MSH

2pm Met with Dr. Baudilio Lopez, USAID

5:30 pm Met with Dr. Carlos Andrade, Director of Public Health Program, Francisco Marroquin University

Wednesday, February 21
Report preparation.

3pm Met with Melody Trott, INCAP Project Liasion, USAID.

Thursday, February 22
Report preparation.

3pm Submitted Conclusions and Recommendations to Jayne Lyons, USAID.

Friday, February 23
Report preparation.

Saturday, February 24
Report preparation.

Sunday, February 25
Report preparation.

Monday, February 26
End of assignment.

CAPACITACION Y SEGUIMIENTO DE COMADRONAS TRADICIONALES 1986 - 1987

AREAS	TOTAL* COMAD.	1986				1987					
		Capaci- tadas.	%	Sin capaci- tación.	%	Capacitación			Seguimiento		
						Progra- mado.	Realiza- do.	%	Progra- mado	Realiza- do.	%
Alta Verapaz	1350	273	20	1077	80	173	305	175	216	165	76
Amatitlán	151	133	73	48	27	50	17	34	35	102	291
Baja Verapaz	414	171	41	243	59	135	33	24	221	173	77
Chimaltenango	486	409	84	77	16	250	81	32	253	114	45
Chiquimula	485	222	46	263	54	220	79	35	253	64	25
El Progreso	247	192	80	55	20	27	4	-	-	112	-
Escuintla	947	324	34	623	66	179	133	74	192	110	57
Guatemala Norte	258	214	83	44	17	99	20	20	151	55	36
Guatemala Sur	155	124	80	31	20	100	30	30	145	31	21
Huehuetenango	1566	724	46	842	54	500	207	41	862	241	28
Izabal	328	145	44	183	56	23	42	183	217	86	40
Jalapa	351	256	73	95	27	70	47	67	380	150	39
Jutiapa	623	262	42	361	58	150	101	67	477	-	-
Petén	329	174	53	155	47	186	96	52	139	48	35
Quetzaltenango	1173	533	45	640	55	251	193	77	405	142	35
Quiché	1047	433	41	614	59	379	182	48	405	136	34
Retalhuleu	185	158	85	27	15	125	18	14	101	93	92
Sacatepéquez	138	83	60	55	40	47	30	64	94	30	32
San Marcos	1279	466	36	813	64	720	223	31	730	382	52
Santa Rosa	483	331	69	152	31	90	-	-	411	356	87
Sololá	493	274	56	219	44	156	68	44	304	149	49
Sucitepéquez	668	285	43	383	57	166	118	71	288	78	27
Totonicapán	562	378	67	184	33	260	66	25	455	154	34
Zacapa	160	125	78	35	22	12	-	-	237	134	57
TOTAL :	13908	6689	48	7219	52	4368	2093	48	6974	3105	45

*Datos Programación 1987.

APPENDIX D

BIBLIOGRAPHY

1. Cosminsky, Sheila, "El Papel de la comadrona en mesoamerica", America Indigena, Vol 37, No.2, Abril-Junio, 1977.
2. Cosminsky, Sheila, "Cross-Cultural Perspectives on Midwifery, In: Grolig, F. and Haley, H., eds. Medical Anthropology. The Hague, Netherlands, Nouton Press, 1976. p. 229-248.
3. Guatemala: Encuesta Nacional de Salud Materno Infantil, 1987, Ministerio de Salud Public y Asistencia Social, Instituto de Nutricion de Centro America y Panama, Demographic and Health Surveys, Institute for Resource Development/Westinghouse, Preliminary Final Report, 1988.
4. "Supplement II: Traditional Birth Attendants, An Annotated Bibliography on their Training, Utilization and Evaluation," World Health Organization, Division of Health Manpower Development, Geneva, 1982, p. 2-3.
5. "Capacitacion y Seguimiento de Comadronas Tradicionales 1986-1987", Ministry of Health Document.
6. Untitled Ministry of Health document describing case studies of promoter and TBA activities in support of ORT and EPI in eight communities.
7. Manual para el Equipo Adiestrador de Comadronas Tradicionales, Cuarta Revision, Departamento de Materno Infantil, Ministerio de Salud Publica y Asistencia Social, Guatemala, 1980.
8. Situacion actual del Promotor Rural de Salud en el Pais, Departamentos de Investigacion y Salud Comunitaria, Division de Recursos Humanos, Direccion General de Salud, Ministerio de Salud y Asistencia Social, Guatemala, Diciembre, 1987.
9. "Estudio de las Caracteristicas y Practicas de las Comadronas Tradicionales en una Comunidad Indigena de Guatemala", Ethnomedicina en Guatemala, pg. 251 - 263.
10. Cosminsky, Sheila, "Role adaptation among indigenous midwives: A case study in a Guatemalan mayan community", undated.
11. Cosminsky, Sheila; "The Role and Training of Traditional Midwives"; Prepared for the panel, Health Care Policy in Africa and Latin America, African Studies and Latin American Studies Association Meeting, Houston, Texas, Nov. 4, 1977.
12. Kelly, Isabel, "An Anthropological Approach to Midwifery Training in Mexico"; The Journal of Tropical Pediatrics; Vol 1, No. 3, March, 1956, pg 200 - 205.
13. Cosminsky, Sheila; "Childbirth and Midwifery on a Guatemalan Finca", Medical Anthropology, Vol 1, No.3, Summer 1977, pg 69 - 103.
14. Proyecto A-1, "Validacion de Indicadores de Riesgo de Bajo Peso al Nacer y Desarrollo de Tecnologia Apropiaada para Evaluacion Clinica de Crecimiento Fetal", INCAP, undated.
15. Proyecto C-1, "Investigacion Evaluativa sobre la Atencion Materno Infantil Proporcionada por la Comadrona Tradicional y Opciones para Mejorarala", INCAP, undated.
16. Pineda, M.A. et al.; "Increasing the Effectiveness of Community Workers through Training of

- Spouses: A Family Planning Experiment in Guatemala"; Public Health Reports; Vol. 98, No. 3, May - June, 1983; pg. 273 - 277.
17. "Traditional Birth Attendants: A Resource for the Health of Women", Reprinted from the International Journal of Gynecology and Obstetrics; Vol 23, 1985; Pgs. 247 - 303.
 18. Delgado, Hernan, Valverde, Victor and Hurtado, Elena; "Case Study on Infant Mortality, Primary Health Care and Nutrition in Rural Guatemala", Institute of Nutrition of Central America and Panama, circa 1980.
 19. Paul, Lois; "The Mastery of Work and the Mystery of Sex in a Guatemalan Village"; Woman, Culture and Society; Stanford University Press, 1974, pg. 219 - 339.
 20. Paul, Lois; "Careers of Midwives in a Mayan Community", Women in Ritual and Symbolic Roles; Plenum Publishing Corporation, 1978, pg. 129 -149.
 21. Paul, Lois and Paul, Benjamin; "The Maya Midwife as Sacred Specialist: a Guatemalan Case"; American Ethnologist; Vol 2, No. 4, November, 1975, Pg. 707 - 726.
 22. Reyes, Petra; "Assessment of the Training Program of the Primary Health Care Component of the Community-Based Health and Nutrition Systems Project of Guatemala", American Public Health Association, International Health Programs, 1983.
 23. "Encuesta Nacional Comunitaria de Conocimientos, Actitudes y Practicas de Salud Materno Infantil - Descripcion General de las Principales Variables del Estudio", Ministerio de Salud Publica y Asistencia Social y Instituto de Nutricion de Centro America y Panama (INCAP), Guatemala, 1987.
 24. "Encuesta Nacional Simplificada de Salud y Nutricion Materno Infantil, Informe Final", Ministerio de Salud Publica y Asistencia Social y Instituto de Nutricion de Centro America y Panama, Guatemala, Agosto, 1986.
 25. Guitierrez Pineda, Miguel; "Evaluacion de las Actividades Desarrolladas por las Comadronas Tradicionales Adiestradas por la D.G.S.S. en el Departamento de Totonicapan"; Tesis, Universidad de San Carlos de Guatemala, Facultad de Ciencias Medicas, Octubre, 1986.
 26. Jordan, Bridgette; Birth in Four Cultures; Montreal, Canada, Eden Press Women's Publications, 1978.
 27. El Tom, A. R. et al; "Developing the Skills of Illiterate Health Workers"; World Health Forum; Vol. 5, 1984.
 28. "Estudio Sobre la Partera Tradicional", Ministerio de Salud Publica y Asistencia Social, Honduras, 1985.
 29. Maglacas, A. M. & Simmons, J. eds.; The Potential of the Traditional Birth Attendant; World Health Organization, 1986.
 30. Untitled document from Elena Hurtado about health seeking behavior in a ~Guatemalan community.
 31. Normas y Guías de Atención en Centros de Salud, Programa de Salud Materno Infantil; Departamento Materno Infantil, Ministerio de Salud Publica y Asistencia Social; 1986 y 1988.
 32. "Permanence of the Primary Health Care Component of the Health and Nutrition Integrated Community Systems Project"; Kraus International, Inc.; February, 1988.
 33. WHO Safe Motherhood Conference 1987, Report.

34. "The Extension of Health Service Coverage with Traditional Birth Attendants: A Decade of Progress"; WHO Chronicle; Vol 36, No.3; 1982, pg. 92 - 96.
35. "Capacitacion y Seguimiento de Comadronas Tradicionales", Departamento Materno Infantil, Direccion General de Servicios de Salud, Ministerio de Salud Publica y Asistencia Social, Guatemala, 1988.
36. "Informe Seminario-Taller para Revision y Actualizacion de la Actividad de Comadronas", Departamento de Salud Materno Infantil, Direccion General de Servicios de Salud, Ministerio de Salud Publica y Asistencia Social, Guatemala, 1985.
37. Pebley, Anne & Stupp, Paul; "Reproductive Patterns and Child Mortality in Guatemala", Office of Population Research, Princeton University, 1985.
38. Garcia, B., Urrutia, J. J. & Behar, M.; "Creencias y Conocimientos sobre Biologia de la Reproduccion en Santa Maria Cauque", Guatemala Indigena, 1983; p 53 - 81.
39. "Traditional Birth Practices: An Annotated Bibliography"; Maternal and Child Health Unit, Division of Family Health, World Health Organization, Geneva.
40. "International Perspective: The Midwife's Role in Promoting Safe Motherhood"; Journal of Nurse Midwifery; Vol. 33, No. 4, July-August, 1988; p. 155 - 158.
41. Leedam, E.; Traditional Birth Attendants, Int. J. Gynaecol. Obstet., International Federation of Gynaecology & Obstetrics, Ireland, 23 (1985) 249-274.
42. Lewis, J.H., Janowitz, B. and Potts, M.; "Methodological Issues in Collecting Data from Traditional Birth Attendants", Int. J. Gynaecol. Obstet., International Federation of Gynaecology & Obstetrics, Ireland, (1985) 23:291-303.
43. "Expansion of Family Planning Services," 1988 Project Paper Supplement, USAID/Guatemala.
44. Bossert, T. and del Cid Peralta, E.; "Guatemala Health Sector Assessment, 1987 Update," Guatemala, December 1987.
45. Smith, G.; "Mid-Term Evaluation Report, PCI/Guatemala Child Survival Project, Santiago, Atitlan, Guatemala, October 1988.
46. ASECSA; "Materno Infantil"; Manual for TBA Training, Chimaltenango, Guatemala, 1984.
47. Portes Carrasco, R.; "Reporte de Evaluacion de la Asistencia del Fondo de las Naciones Unidas para Actividades en Materia de Poblacion al Proyecto Extension y Reforzamiento de las Servicios de Salud con Enfasis en Materno Infantil y Bienestar Familiar de Guatemala.", Guatemala, August 1987.
48. Harrison, P., "Analysis del Sector Salud de Guatemala, Un Estudio Sobre las Comadronas"; AID, November 1977.
49. Andrade, C.; "Programa Docente Asistencial de Salud Rural, San Juan Sacatepequez, Informe Annual, 1987", Facultad de Medicina, Universidad Francisco Marroquin and MOH, Guatemala, 1988.
50. "Traditional Midwives and Family Planning", Population Reports, Series J, Number 22, Population Program, The Johns Hopkins University, Baltimore, MD, USA, May 1980.
51. "Mothers' Lives Matter: Maternal Health in the Community." Population Reports, Issues in World Health, Series L, Number 7, Population Information Program, Center for Communication Programs, Johns Hopkins University, Baltimore, MD, USA, September 1988.
52. Andrade, C., Palacios, J., Herman, M.O.; "Trabajo de Investigacion"; Enero, 1989.

APPENDIX E

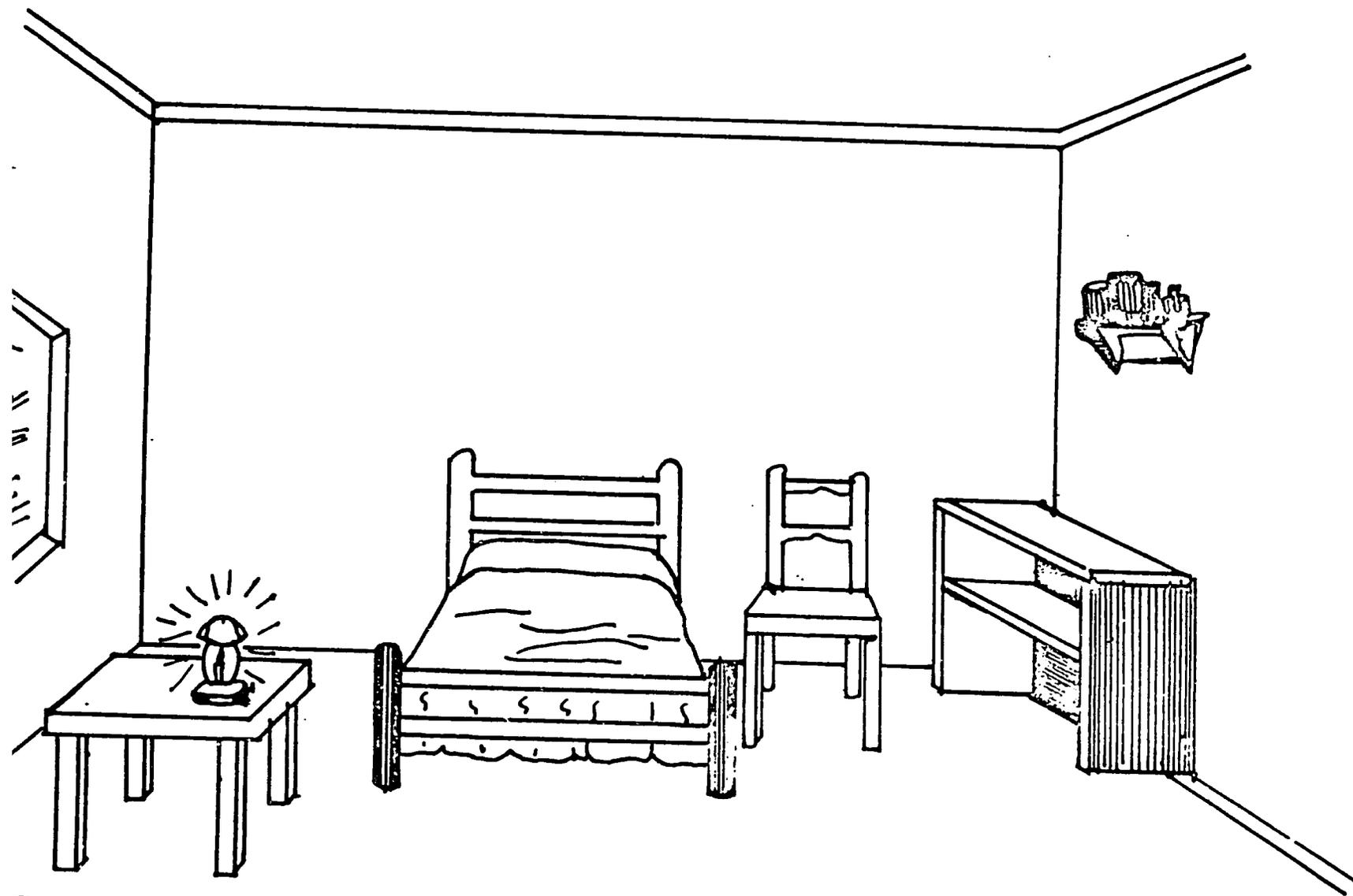
ACRONYMS

AGES	Asociacion Guatemalteco de Educacion Sexual
AID	Agency for International Development (Washington)
APROFAM	Asociacion Pro Familia (IPPF affiliate)
ARI	Acute Respiratory Infection
ASECSA	Asociacion de Servicios Comunitarios de Salud
CBHW	Community Based Health Worker
CS	Child Survival
EPI	Expanded Program in Immunization
GOG	Government of Guatemala
INCAP	Instituto Nutricional de Centro America y Panama
KAP	Knowledge, Attitudes and Practices
MCH	Maternal and Child Health
MOH	Ministry of Health
ORT	Oral Rehydration Therapy
PCI	Project Concern International
PRINAPS	Programa de Investigacion de Adiestramiento del Promotor Rural
SINAPS	Sistema Integrado de Nutricion y Atencion Primaria de Salud
TBA	Traditional Birth Attendent (comadrona)
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development

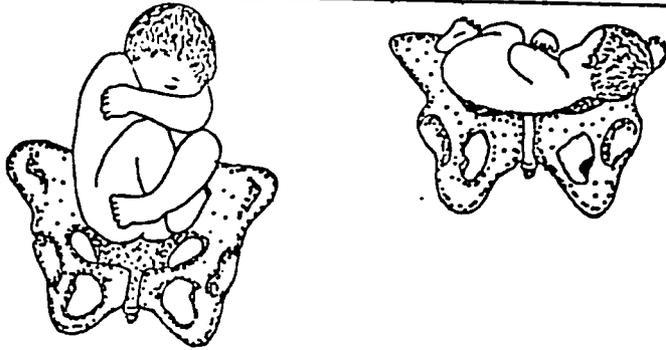
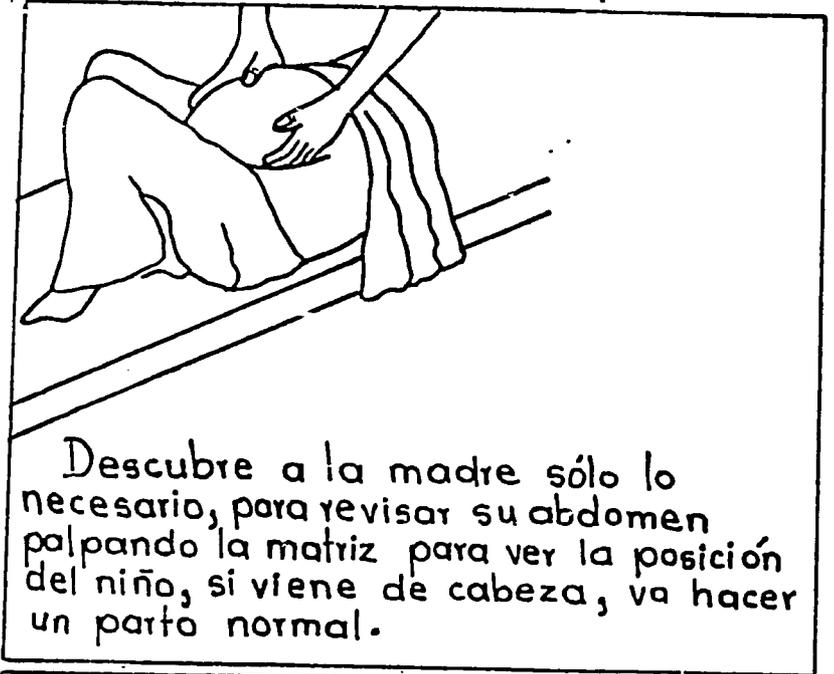
EL PARTO



PREPARACION DEL AMBIENTE PARA LA ATENCION DEL PARTO

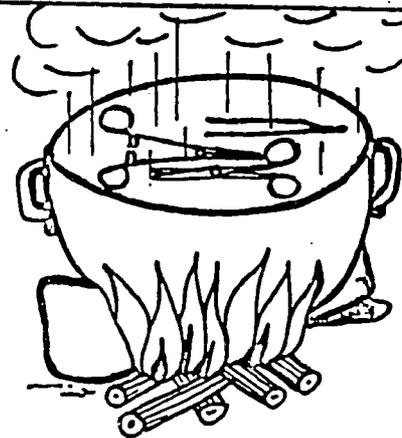


Primer Período: Lo que hace la comadrona o persona que atiende el parto.



Si al palpar a la madre, encuentra que el niño está en una posición anormal: sentado o atravesado, se le llevará inmediatamente a la madre al médico o al hospital.

No tratará de voltearlo, ni le dará ninguna medicina.

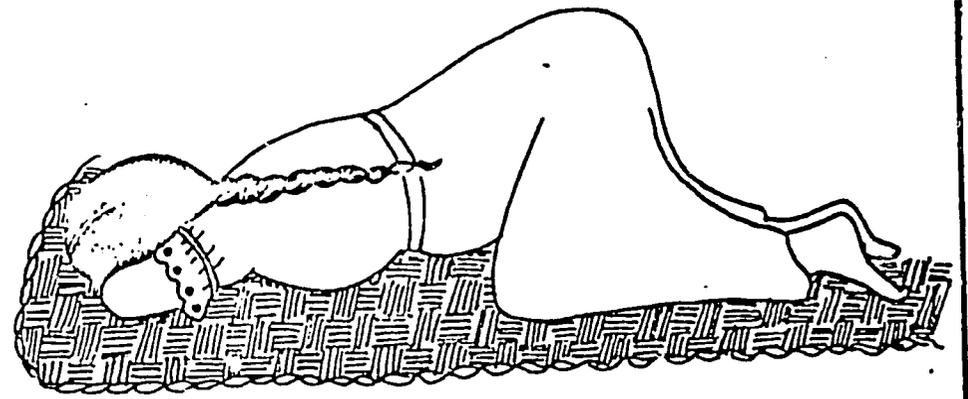


Prepara lo que va a servir para atender el parto, pone al fuego la ollita del niño, para hervir las tijeras, ligaduras para el cordón y los trapitos que le servirán.



Presentación Tranversa o de Hombros
 si el niño viene de hombros o atravesado se llama Presentación Transversa o de Hombros, si la señora tiene 6, 7 u 8 meses de embarazo, aconsejarle que trate de cambiar la posición del niño con los ejercicios que están al lado. Si ya no se voltea el niño o la madre tiene 9 meses ya de embarazo, aconsejarle que vaya al hospital cuando empiezan los dolores ya que tiene que operarse, si no se puede morir ella o el niño.

En estos casos "muchas veces la matriz se extiende mas a los lados y no tanto por delante". Al palpar la matriz, la cabeza no se encuentra por abajo, si no a un lado. Esta es una presentación muy peligrosa para la vida del niño y la madre si no se "OPERA"

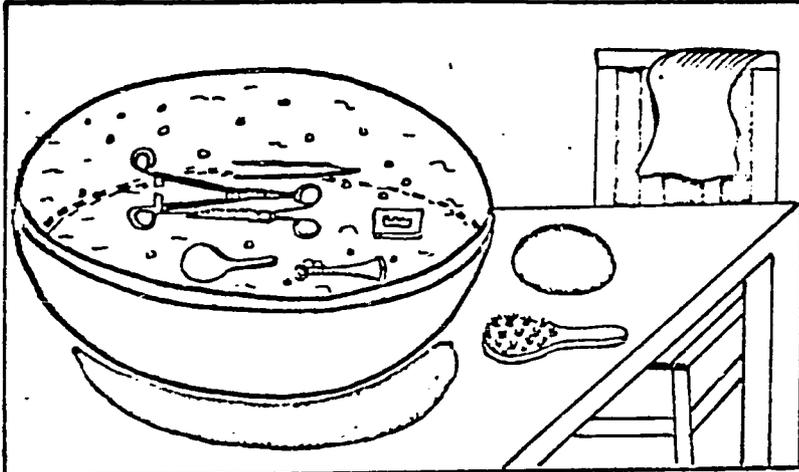


Como Puede Cambiarse la Presentación del Niño que viene sentado y Transversa

1. Entre los niños que nacen diariamente, 95 vienen de cabeza, es el nacimiento normal, más fácil para la madre y seguro para el niño.
2. Cuando descubrimos palpando la matriz en el séptimo mes que un niño viene sentado (de nalgas o atravesado) debemos aconsejar a la madre así: Ponerse de rodillas e inclinarse con la cabeza sobre los brazos en el suelo, quedarse en esta posición por 10 minutos 2 veces al día.
 - Es bueno tener una hora fija para hacer el ejercicio para no olvidarse: 10 minutos antes de almuerzo y 10 minutos antes de cena.
 - Hacer esto todos los días, hasta que el niño se ponga cabeza abajo. Por lo menos 4 a 6 semanas.
 - Es la misma posición que dá alivio al dolor causado por almorranas o várices del ano durante el embarazo.
 - Si se prefiere se puede lograr lo mismo acostado con las caderas elevadas como una cuarta y media más alta que la cabeza.

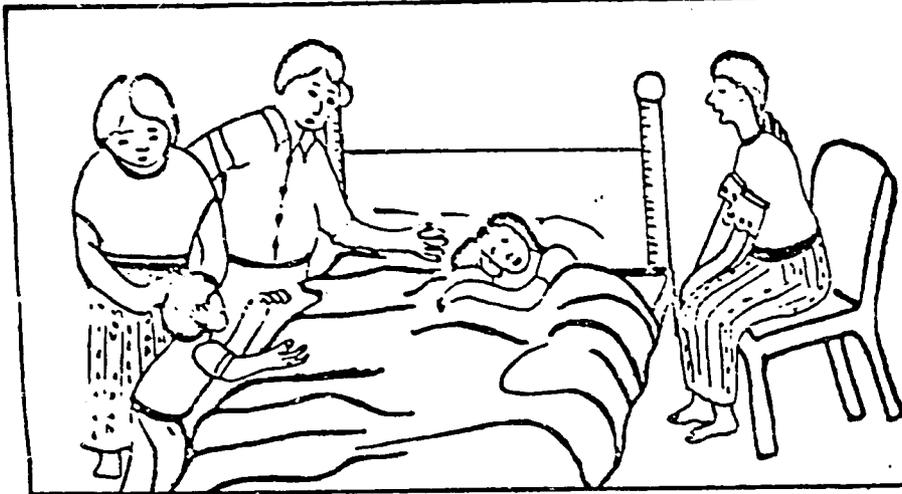
La mayoría de los niños se voltean cuando uno es fiel a los ejercicios.

Cuidados a la Madre Después del Parto o Puerperio

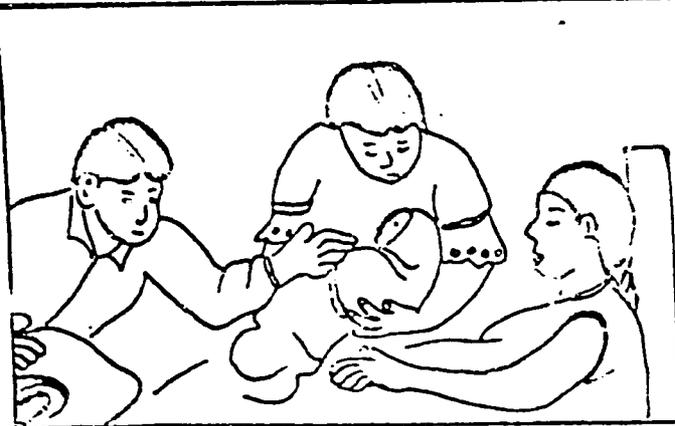


La comadrona, promotor o persona que atendió el parto, limpia sus instrumentos y todo lo que utilizó durante el parto, guarda en su maletín lo que le servirá para la próxima vez y tira lo sucio que tiene en la bolsa de nylon.

Trata de que la casa quede ordenado y limpio para ayudar al ambiente de la madre.



Es muy importante que la persona que atendió el parto oriente a la familia de la parturienta sobre la atención de la madre y del niño, así como de la importancia del control Post-Parto en el hospital, centro de salud o el médico.



También que dé confianza y seguridad a la madre, le de apoyo con alegría para que la madre se sienta bien y serena, además "orgullosa de su trabajo"

APPENDIX G

SUMMARY OF PREVIOUS EVALUATION RECOMMENDATIONS

1. Harrison, 1977

- That support be provided to carrying out innovations in training strategies and content. Support should be provided to training of supervisors and trainers, program evaluation, restructuring the curriculum and/or pilot training projects in remote areas.
- Impact evaluation of the training program, especially looking at the differences in utilization of the trained and untrained midwives by the population.
- That two separate courses be developed. One clinic-based for TBAs near the health centers and hospitals and the second for TBAs in remote areas who really have life and death situations in their hands.
- That the sequence of training be changed to emphasize the most important concepts first, thus assuring maximum benefit for the considerable proportion of TBAs that never finish the course.
- That the philosophy of the training be changed requiring the acceptance of the idea that modern and traditional medicine are not mutually exclusive.
- Evaluation of the potential harm and benefit of traditional practices.
Evaluation of the impact of the trained TBA on her practice.

2. Reyes, 1983

- That the insufficiently developed components of the training system, i.e., evaluation methodologies and a training information system, should be developed as soon as possible. Full implementation of the supervision/information system should be given top priority.
- A training management plan must be developed concurrently with a revised and detailed program implementation plan. Training should be decentralized in accordance with the systems management plan.
- Evaluation methodologies should be given priority. Particularly important are methods for pretesting, interview progress testing and post testing the mastery of key learning points for community-level personnel. A training information system must be established. This should include a good

registry of courses, trainees and their performance levels and the effectiveness of the trainers themselves. The training information system should be linked with the supervision/information system.

- A simplified training guide should be developed for the auxiliaries. It should focus on essential teaching points and skills to be practiced by the trainee and should provide the trainee with specific learning experiences designed to teach the point or skill. Concomitantly, effective measurement techniques for assessing comadrona learning must be developed. Based on training evaluation and supervisory follow-up, the curriculum for comadronas should be reviewed, possibly narrowed, and made more specific to essential skills.
- Training of the auxiliaries as trainers should be carried out, upgrading their skills and training should be less didactic and more experience-centered and participatory.

3. MOH, August, 1985 TBA Workshop/Seminar

- "...implica considerarla como un ser que posee todo un rico bagaje caracterizado por su propia escala de valores, sus creencias, costumbres y practicas, razon por la cual se enfatizo que es prioritario conocer profundamente su quehacer lo cual significa sumergirse en esa riqueza."
- Accept and truly and formally incorporate the TBA within the health services.
- Establish adequate coordination with the Division of Human Resources and with the professional schools in training activities at all levels.
- Conduct participative and interdisciplinary midwife planning activities.
- Identify TBA training needs, i.e. her occupational profile.
- Effect a change in attitude at all levels of the health care system towards the practices and actions of the TBA.
- Train institutional personnel in the training methodologies and techniques, with a community participation focus.
- Create those conditions which will stimulate and support the activities of the TBA.
- In general, the Health services impose their programs and rarely take into account those aspects of the TBAs own system of beliefs and values.



Presentación

Este folleto contiene conocimientos sobre el embarazo, el parto, el post-parto y otros temas de interés para la madre y el niño, todo preparado para reforzar las experiencias y los conocimientos del promotor de salud y de la comadrona, quienes cumplen un servicio grande y amplio a su comunidad. Este servicio exige mucha responsabilidad e interés por los demás, amor a la vida y conocimiento suficiente para saber qué hacer y cómo hacerlo para contribuir a una vida sana.

Convertirse en madre, en la vida de toda mujer es muy importante.... Entender y apreciar la vida y dignidad de toda persona es muy necesario...conocer el cuerpo humano y cómo funciona es normal y necesario... Contribuir al desarrollo del Programa Materno Infantil establecido en nuestro país; es una responsabilidad...

Por todas estas razones se ha preparado este folleto, teniendo como guía el folleto Materno Infantil del Programa de Promotores de Huehuetenango y resúmen de otros libros.

La mejor satisfacción es que el folleto se entienda, se use y que la comunidad alcance mejores beneficios.

Atentamente:

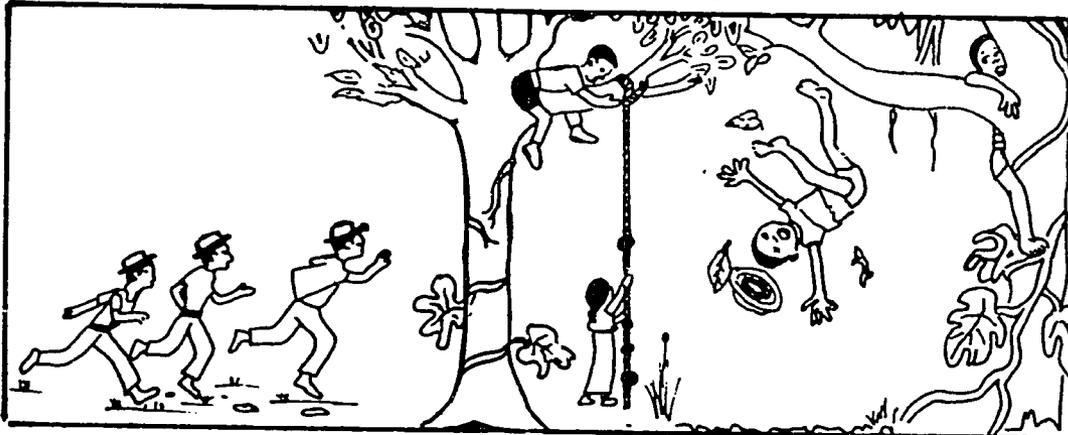
ASECSA

Chimaltenango 1984

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¿Qué es un Niño?



Los niños son de diferente tamaño, peso y color; están dondequiera: encima, debajo, dentro, subidos colgados, corriendo y saltando.

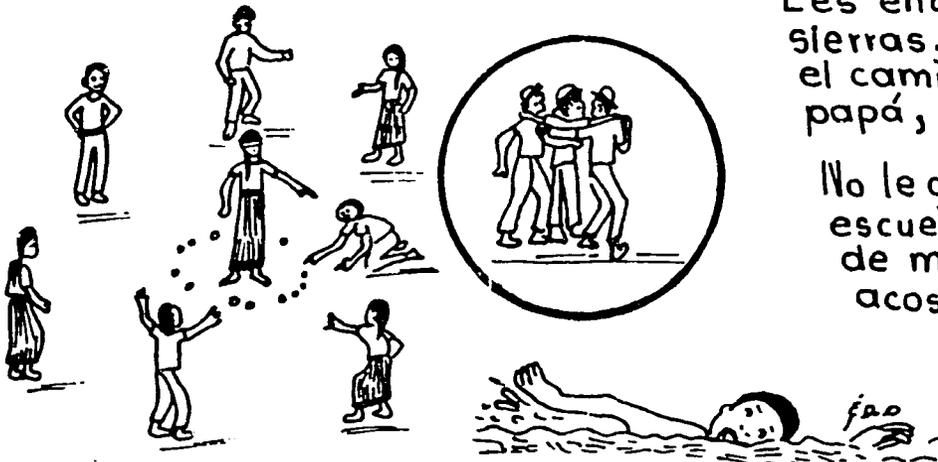


Las mamás los adoran, los hermanos mayores los toleran, los adultos los desconocen y el cielo los protege.

Un niño es la verdad con la cara sucia, la sabiduría con el pelo alborotado y la esperanza del futuro.



Un niño tiene el hambre de un caballo, la digestión de un traga espada y la energía de una bomba atómica, la curiosidad de un gato, los pulmones de un orador, la imaginación de un escritor, la timidez de una violeta, la audacia de una trompa de acero y el entusiasmo de un juguete.



Les encantan los dulces, las navajas, las sierras, las láminas, el chico de los vecinos, el campo, el agua, los animales grandes, su papá, los trenes y los domingos.

No le gustan las visitas, la doctrina, la escuela, los libros sin láminas, las lecciones de música, los adultos y la hora de acostarse.

Nadie se levanta tan temprano, ni se sienta a comer tan tarde. Nadie puede meterse en el bolsillo un lapicero viejo, una fruta mordida, medio metro de pita, dos dulces, cinco centavos y una hon-do.



Un niño es una criatura mágica, usted puede cerrarle las puertas de las herramientas pero no puede cerrarle la puerta de su corazón.

Puede echarlo de un cuarto, pero no puede echarlo de su mente. Todo el poderío suyo se rinde ante él, es su carcelero su jefe y su amo.



Cuando usted llega a casa por la tarde con sus esperanzas y sus ambiciones hechas pedazos, él puede remediarlo con sus palabras mágicas:

"papito," "mamita," "nan," "tat" .

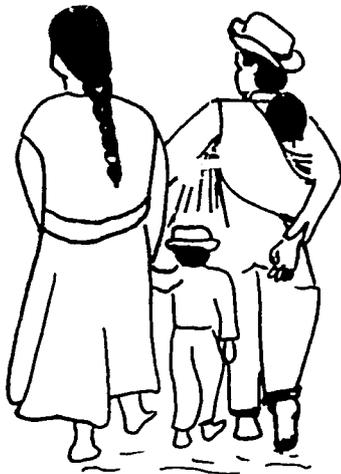
Este es un niño ¿Que ha hecho usted por él?



¿ Qué es un joven ?

Hace algunos años era niño, dentro de poco será un adulto, pero por ahora, como joven no tiene la responsabilidad del adulto y no ha perdido completamente su fantasía, ahora le llama la atención el otro sexo, le gusta ser, no le gusta por no comprender y se escapa de las normas familiares.

Cuando usted llega cansado y desesperanzado de la jornada del día; no siempre será la varita mágica que alivia la situación, sino muchas veces, da motivo a otro disgusto a los padres y los padres a él.



¿ Qué son el Hombre y la Mujer ?

El hombre y la mujer no son contrarios sino complemento. Por eso no se hablará del otro sexo como el sexo opuesto, sino como el sexo complementario, entre quienes existirá respeto y estima sobre lo que vale cada quien y de lo que es capaz de dar.



La mujer es sometida por el hombre: el padre, el hermano y el esposo; por eso trata de hacer del hijo como un reflejo del hombre leal y amoroso que no tiene y lo malcría, llegando él a ser igual que su padre.

A la hija la trata de la misma manera que ella fue criada. De este modo se mantiene el modelo del hombre que la mujer misma ayuda a crear.

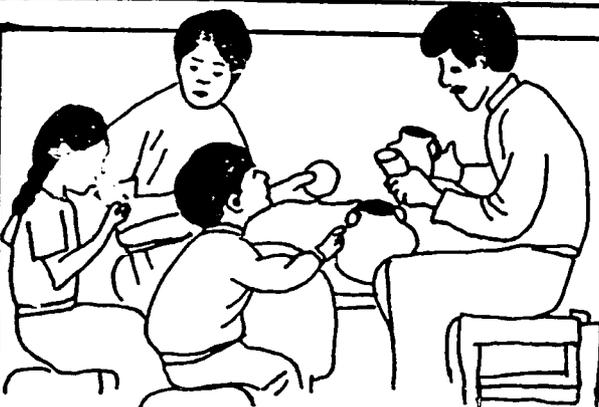


Para crear al nuevo hombre es necesario que la mujer cambie.

Sólo cuando ella se estima, se aprecia será tratada con aprecio, estima y respeto.



Cada parto enaltece a la mujer, pero no es sólo la maternidad lo que la enaltece sino toda su personalidad, toda su vida, todo su trabajo.



El lugar que el hombre ocupa en la familia y la comunidad no depende de su fuerza, su autoridad ni de la cantidad de hijos que tenga; sino del bienestar de vida que él dé a sus hijos, a sus hijas y a su esposa.

Para lograr la igualdad y lo complementario de Hombre y Mujer, es necesario quitar todas las formas de desigualdad que el niño y la niña viven desde pequeños.

Para eso sugerimos analizar parte por parte el siguiente cuadro:



Actividades Femeninas

1. Juegan con muñecas.
2. Juegan a la familia.
3. Si hay posibilidad estudian.
4. Al terminar las tareas de la escuela ayudan a cocinar.
5. Sirven y obedecen al hombre.
6. No hacen competencia.
7. Son madre y amas de casa.
8. Satisfacen a los hombres.
9. Son atractivas y sin defensa.
10. Se les paga menos su trabajo.



Actividades Masculinas.

1. Juegos con carretas y cajones
2. Juegos de escondite y competencia
3. Se hace todo lo posible para que estudie..
4. Al terminar las tareas de la escuela pueden ir a jugar y descansar.
5. Mandan a la mujer a que los sirvan.
6. Hacen competencia.
7. Son proveedores y protectores.
8. Son complacidos por la mujer.
9. Son fuertes y poderosos.
10. Se les paga mejor.



¿ Qué quiere decir Materno Infantil?

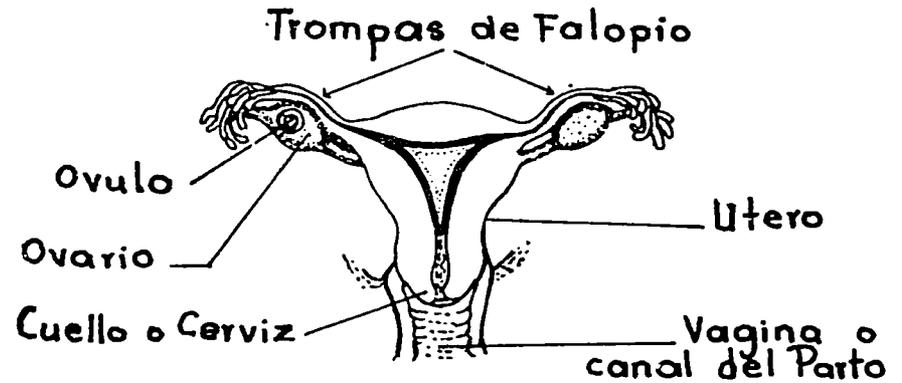
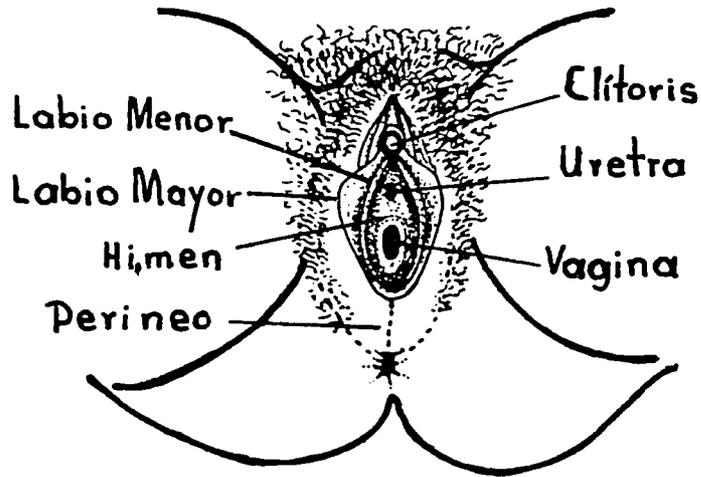
- Quiere decir Madre e Hijo.
- Es un programa de Salud del país que se dedica a atender al niño y a la madre para mejorar su estado de salud, pues actualmente mueren muchos niños antes de cumplir 5 años, y las madres sufren desnutrición, muchas dificultades en la atención del parto y varios problemas después del parto.

Las Partes del Cuerpo de la Mujer que Ayudan a la Formación del Niño se llaman: ORGANOS REPRODUCTORES FEMENINOS

Se dividen en dos:

Externos o de Afuera

Internos o de Adentro.



Labios Menores: cubren la abertura vaginal y la abertura urinaria por dentro.

Labios Mayores: cubren la abertura vaginal, la abertura urinaria y a los labios menores.

Clitoris: parte muy sensible de la mujer, en el hombre es el pene.

Uretra: está entre la abertura vaginal y el clitoris, por aquí sale la orina.

Himen: membrana delgada y en algunos casos firme, que cierra en parte la entrada a los órganos de adentro de la mujer, puede tener forma de anillo o media luna y deja salir la menstruación.

Todos estos órganos externos de la mujer es lo que se llama también vulva.

Óvulo: la semilla que crece para formar el nuevo ser.

Ovario: órgano donde se forman los óvulos.

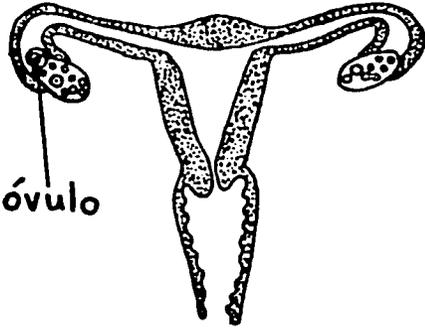
Trompa de Falopio: canales o camino por donde pasa el óvulo para llegar al útero.

Útero o Matriz: órgano vacío en forma de pera invertida, donde crece el niño después de la concepción, mide solo 7 centímetros de largo. Cuando no hay embarazo, se comunica con las trompas de falopio en la parte de arriba y con la vagina en la parte de abajo.

Vagina: órgano en forma de tubo, sirve de entrada al útero. Por aquí entran los espermatozoides del hombre a la mujer y por aquí sale el niño al momento de nacer.

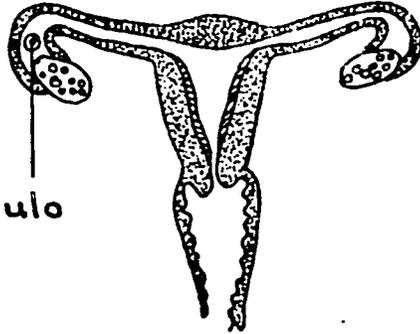
La Regla o Menstruación:

Salida de sangre que normalmente sucede cada 28 a 30 días y tarda 3 o 5 días. Es una señal de que la niña pasa a mujer y puede ya ser madre.



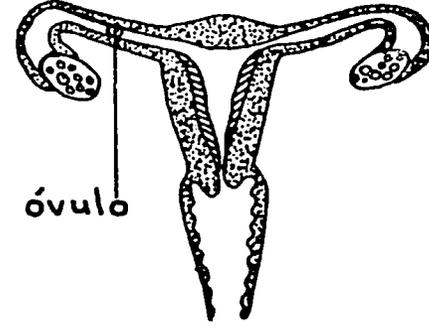
óvulo

La matriz o útero prepara su nido para esperar a una nueva criatura.



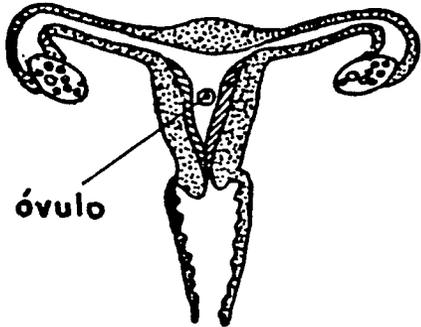
óvulo

El día de la ovulación el óvulo o semilla de la mujer sale de los ovarios y es recogido por las trompas de falopio que lo llevan hacia la matriz, esperando a la semilla del hombre para unirse (ser fecundado).



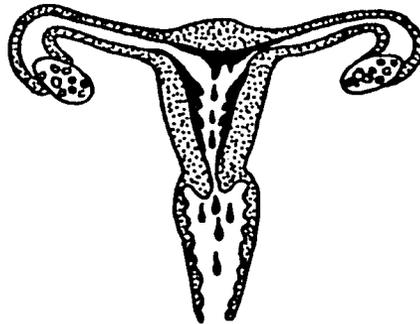
óvulo

La trompa de falopio sigue empujando al óvulo hacia la matriz, esperando a la semilla del hombre para unirse (ser fecundados).

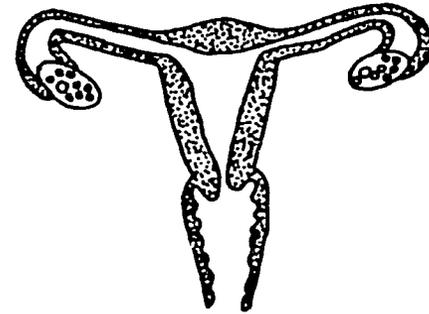


óvulo

El óvulo llega a la matriz sin encontrar la semilla del hombre o espermatozoide, no ha sido fecundado y sale por la vagina.



La matriz deshace el nido porque no hubo embarazo empieza a bajar la regla, 14 días después de la ovulación.

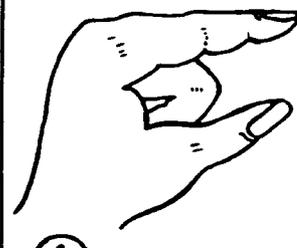


La matriz sigue vaciando hasta quedar limpio y empieza de nuevo a preparar su nido para el próximo mes.

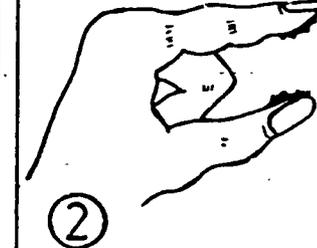
Estos días se puede comer de todo, se puede y es necesario bañarse o lavarse las partes diariamente.

El Flujo Mucoso: como signo de ovulación

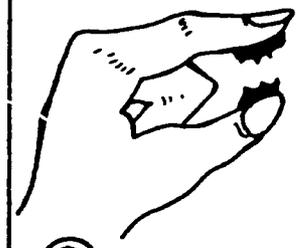
Cuando sale la semilla de su lugar para pasarse a la Trompa de Falopio se llama "ovulación"



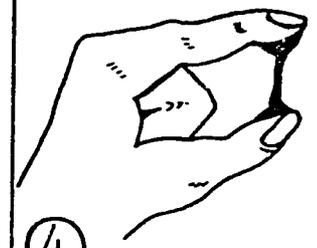
① Al principio la mujer siente seco en las partes de afuera (externas). En estos días se tiene relaciones sexuales, no hay embarazo por no haber flujo mucoso que alargue la vida del espermatozoide.



② Luego desaparece esa sequedad, la mujer se siente algo húmeda en sus partes, y si revisa antes de orinar hay flujo mucoso, levantando un poco con el pulgar y el dedo índice lo encuentra espeso y opaco, blanco o amarillento, pegajoso, pero no elástico, no corre, esto es señal de días fértiles, es probable que las relaciones sexuales resulten en embarazo o concepción.



③ Después aumenta la cantidad de flujo mucoso señalando el tiempo exacto de la ovulación que se acerca, es más blanco, algo elástico más claro, más resbaloso líquido, empieza a ser **ralo**. Aquí las relaciones sexuales resultan en embarazo, porque se prolonga la vida del espermatozoide.



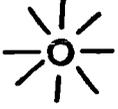
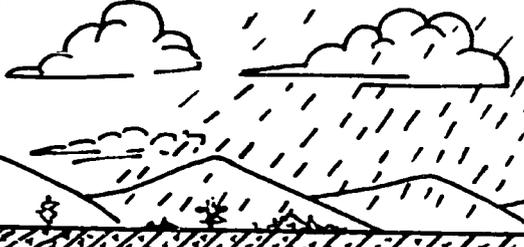
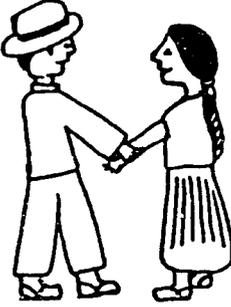
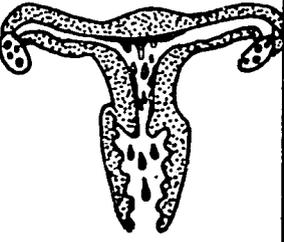
④ y por último, la señal más segura de la ovulación es: el flujo es muy claro, se puede estirar bastante, como clara de huevo resbaloso, puede durar uno o dos días; produce una sensación lubricante (resbaloso), el último día de esta sensación es el día "cumbre" ya que es el día de máxima fertilidad.

La bajada del flujo Mucoso es la base del método de Planificación familiar llamado: Método de la Ovulación.

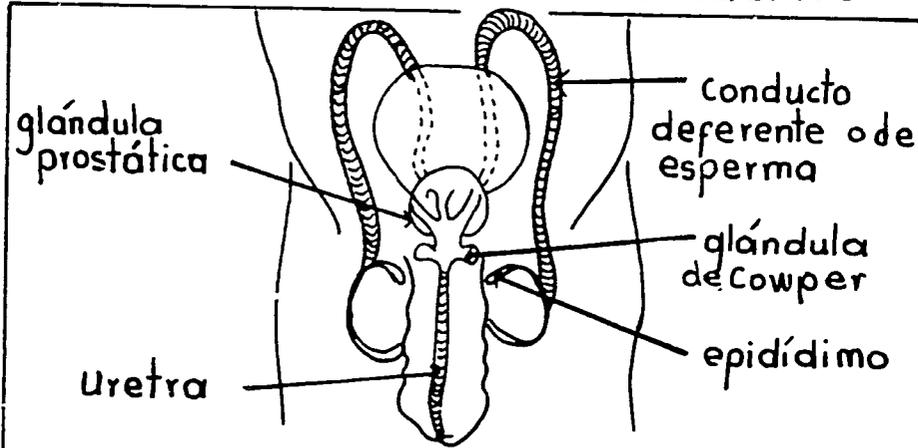
Para mayor comprensión de este método se recomienda que la mujer observe este flujo desde que tiene la primera menstruación. El flujo baja entre una menstruación y otra.

La mujer debe aprender a reconocer sus días HUMEDOS y SECOS, cada mujer es diferente.

La madre tierra tiene sus tiempos fértiles o húmedos y sus tiempos secos. La semilla brota cuando está sembrado en tierra húmeda y cuando aparenta estar seca pero por debajo está húmeda. Lo mismo sucede con la mujer.

				
<p>Verano- seco</p>	<p>Invierno - fértil</p>	<p>seco fértil</p>	<p>Verano- seco</p>	<p>continúa días - Secos</p>
 <p>días seguros no hay niño.</p>	 <p>puede quedar embarazada si hay contacto sexual.</p>		 <p>días secos-seguros no viene niño.</p>	 <p>días de la regla o menstruación</p>
<p>1 2 3 4</p>	<p>1 2 3 4 5 6 7 8 9</p>	<p>1 2</p>	<p>1 2 3 4 5 6 7 8 9</p>	<p>1 2 3 4 5</p>
<p>días- Secos</p>	<p>días húmedos o fértiles con flujo blanco, mas dos días</p>		<p>días secos</p>	<p>puede haber relación sexual, sin haber embarazo.</p>

Las Partes del Cuerpo del Hombre que Ayudan a la Formación del Niño se llaman: **ORGANOS REPRODUCTORES MASCULINOS**. Estos órganos se dividen en dos: **Internos o de Adentro** y **Externos o de Afuera**. 11



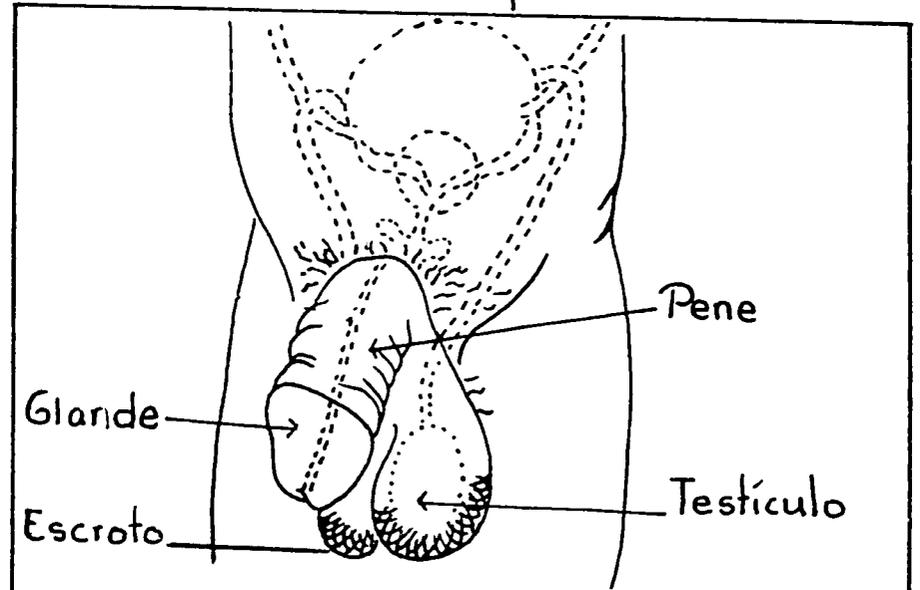
Glándula Prostática: está debajo de la vejiga, durante la relación sexual, esta glándula se contrae y agrega al semen sus propias sustancias. A veces en señores grandes este glándula se agranda y no permite orinar.

Conducto Deferente: llevan los espermatozoides o semillas del hombre del testículo hacia afuera, pasando por la uretra.

Glándula de Cowper: tiene el tamaño de un frijol, está al lado de la uretra, abajo de la glándula prostática, produce un líquido claro y pegajoso antes de la eyaculación.

Epidídimo: están colocados arriba de los testículos. Son tubitos en forma de espiral que guardan los espermatozoides hasta que haya relación sexual y salen o son reabsorbidos por los testículos.

Uretra: es un tubito que está dentro del pene, por allí sale la orina y el semen.

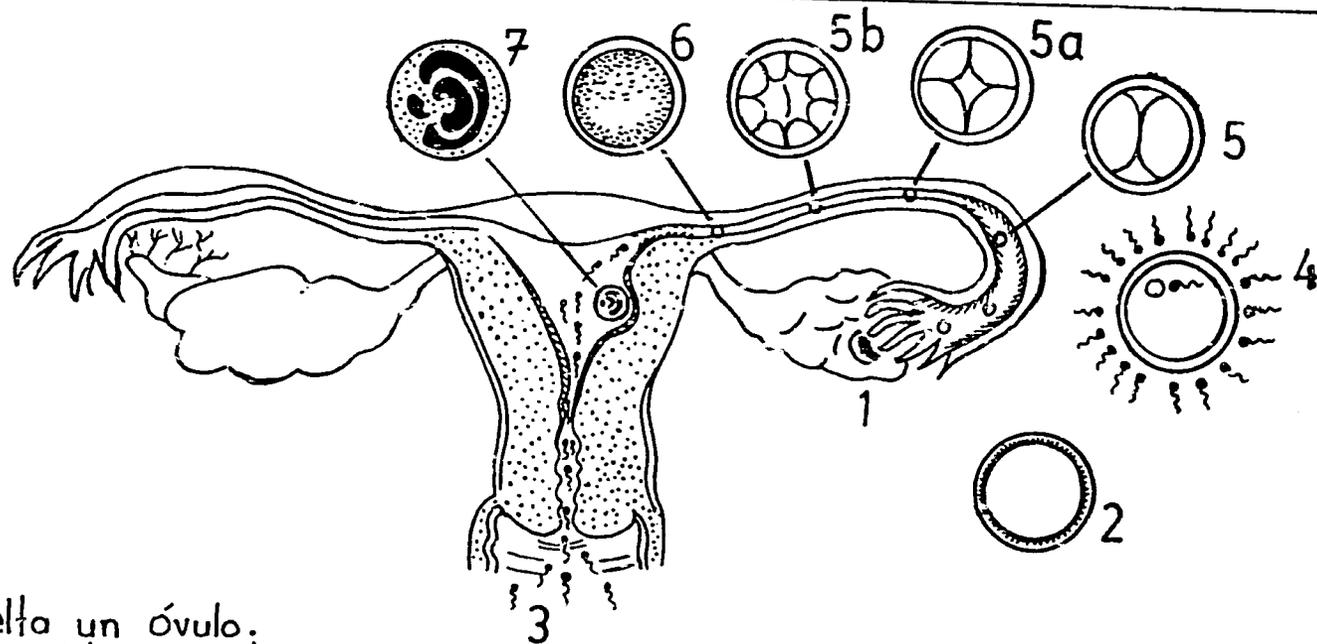


Pene: le sirve al hombre para orinar y hacer la relación sexual. Cambia su tamaño normal durante la relación sexual. Adentro se encuentra la uretra.

Glande: es la punta del pene, tiene muchas terminaciones nerviosas. Está cubierta por el prepucio. Cuando quitan el prepucio se llama circuncisión.

Testículo: es una glándula redonda en forma de huevo, produce células llamadas espermatozoides.

Escroto: piel que protege y envuelve a los testículos.



- 1— El ovario suelta un óvulo.
- 2— El óvulo es recogido por la trompa de falopio.
- 3— En la trompa de Falopio vienen al encuentro del óvulo millones de Espermatozoides.
- 4— Muchos Espermatozoides tratan de entrar en el óvulo para fecundarlo, pero sólo uno logra entrar y se realiza la concepción o fecundación.
- 5— ya unidos empiezan a dividirse primero en dos, en 4, después en 8, y así empieza a crecer.
- 6— Fertilizado y dividiéndose cada vez más, baja de la trompa de falopio hacia el útero. Esto se llama ANIDACION del HUEVO.
- 7— Se pega en la pared o Endometrio. El endometrio es como una esponja, llena de sangre preparado por el organismo al suspender la menstruación.

El Embarazo: comienza con la concepción o fecundación al unirse un óvulo y un espermatozoide éstos forman una célula o huevo, esta célula o huevo es el origen del nuevo ser humano: un niño, el que al nacer estará formado de millones de células. Al principio todas las células son iguales, pero poco a poco tienen que hacer tareas especiales, algunos van a formar la piel del nuevo niño, otros los músculos, otros el cerebro, otros los nervios, etc. El niño se desarrolla en el vientre de su madre durante nueve meses. Los tres primeros meses de desarrollo del niño se llama: EMBRION De los cuatro a los nueve meses de desarrollo del niño se llama: FETO

Desarrollo Embrionario

A las 4 Semanas: el embrión ya tiene un pequeño cuerpo redondo con cabeza y tronco. Empieza a formarse el cerebro, la médula espinal, los huesos que lo protegen, los ojos, los oídos, la nariz, los labios, la cara, la garganta, el estómago, los intestinos, el hígado y los riñones.



A los 27 días empieza a latir el corazón.
El embrión mide 5 milímetros de largo.



A las 6 Semanas: si se le tocara las palmas de las manos ya cierra los puños. Si se le tocara los pestañas cierra los ojos. Comienza a formarse las uñas y empieza aparecer cabello sobre la cabeza. Ya se puede distinguir si es nene o nena. El riñón empieza a sacar orina.

A las 12 Semanas:

el embrión mide 8 centímetros de largo y pesa 1 onza. Tiene cerrado los ojos, ya comienza a moverse, estira sus brazos y piernas, mueve la cabeza, abre y cierra la boca. Empieza a tragar las aguas y a orinar. Después de las 12 Semanas se le llama: "Feto".



A las 16 Semanas:

El feto mide 18 centímetros de largo y pesa 5 onzas. Le sale pelo en todo el cuerpo. Empieza a endurecerse sus huesos. La madre comienza a sentir movimientos. Ya se distingue claramente si es hombre o mujer.



Signos Probables de Embarazo: Estos signos son normales. No son una enfermedad.

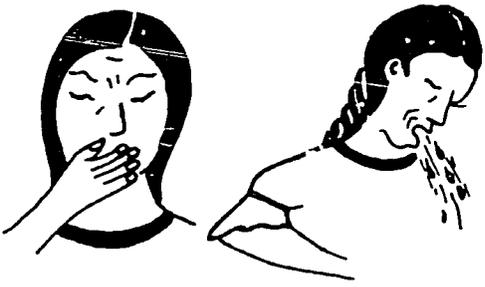


Una mujer puede sospechar que está embarazada cuando:

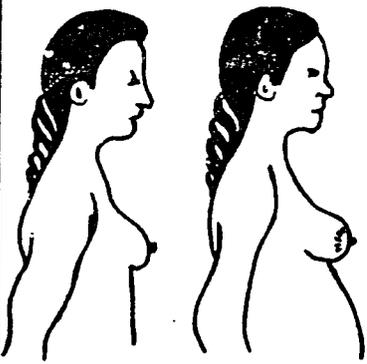
1. No hay menstruación o regla.
2. Dolor de cabeza.
3. Falta de hambre
4. Tiene mucho cansancio sin razón.



5. Ganas de orinar a cada rato, esto en los primeros meses porque el útero crece y aplasta la vejiga.



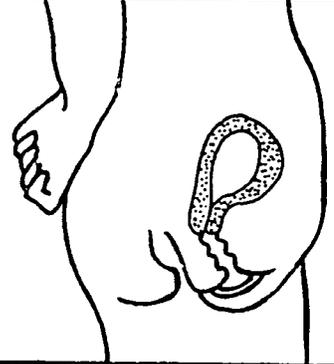
6. Malestar por la mañana, le dá asco, náusea, vómito, por largo tiempo.



7. Crecen los pechos, los pezones se ponen oscuros, da cosquilleo u hormigueo, se ponen duros.

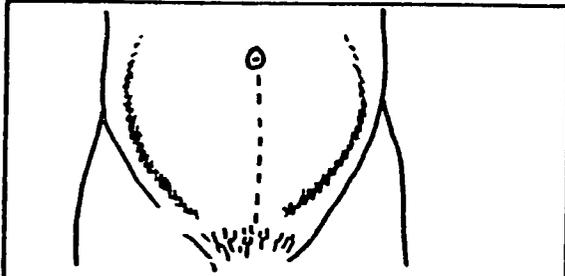
Signos que comprueban el embarazo:

1. Crecimiento del UTERO o MATRIZ, por lo mismo el abdomen también crece.



2. Salida de agua lechosa por los pechos (calostro).

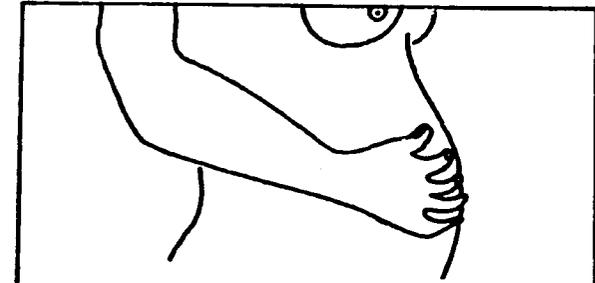




3. Aparece una línea morena más oscura que el de la piel, desde el ombligo hasta el pubis o hueso saliente del vientre.



4. A veces se oscurece la piel de la cara "paño" o cloasma.



5. La madre puede sentir sensación de movimiento

Signos de Certeza de Embarazo:

Los que nos dicen que hay embarazo sin duda son a los 5 meses o más

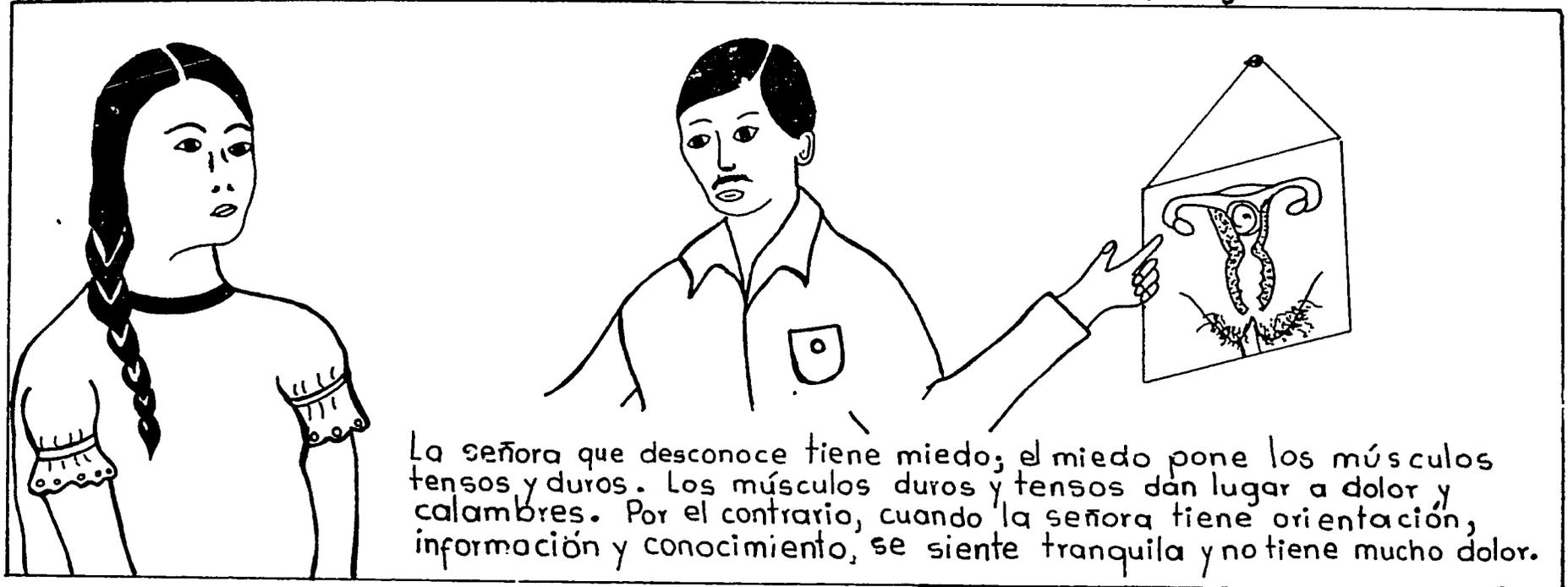
1. Se escucha el ruido de la placenta.



2. Se escucha foco fetal o latidos del corazón del feto. Puede sentir sensación de movimiento y puede ser palpado por el que examina.

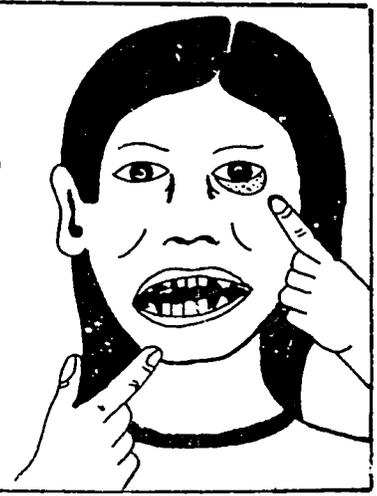


Comunmente el embarazo se desarrolla en forma normal, pero para mayor seguridad del niño y la madre es IMPORTANTE EL CONTROL PRÉNATAL. Para orientar mejor a la madre durante el embarazo; el promotor ha de tener claridad qué malestares son normales y qué malestares son peligrosas.

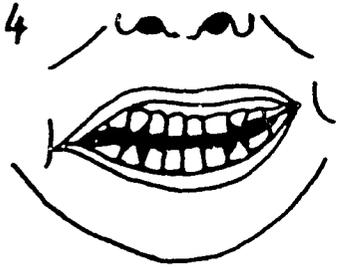


Examen Físico de la Embarazada

1. En la cara es importante examinar: la parte de adentro de los "OJOS," labios y encillas para ver su color: Si están rosados está normal, si están pálidos indican que hay anemia. Si es grave enviarla al médico; si es poco o leve, aconsejarle una buena dieta rica en hierro como hojas verdes, yema de huevo. También ver el color de las uñas.
2. Buscar cualquier inflamación que puede haber en la cara.
3. Ver si hay inchazón. Esto no es normal, es importante explicar a la señora lo peligroso de esto por algún veneno o toxina que puede causarle problema más grave después. Envíela al médico.



4



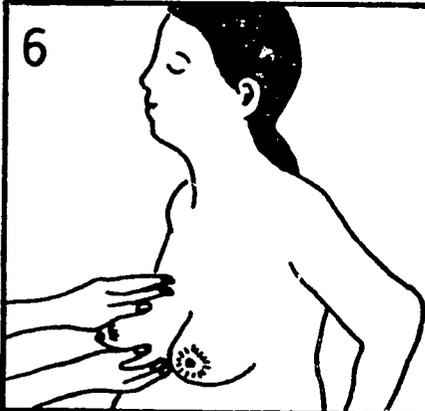
En la boca revisar los dientes, ver si hay caries, picaduras, signos de infección en las encías, inflamaciones. Aprovechando para revisar la garganta. Es importante enviarla al dentista porque el niño que viene necesita muchos minerales como el calcio de los dientes y si no hay los tomará de la embarazada y ella estará propensa a perderlos o a que se le arruinen.
Es importante que la señora aprenda a cepillarse.

5



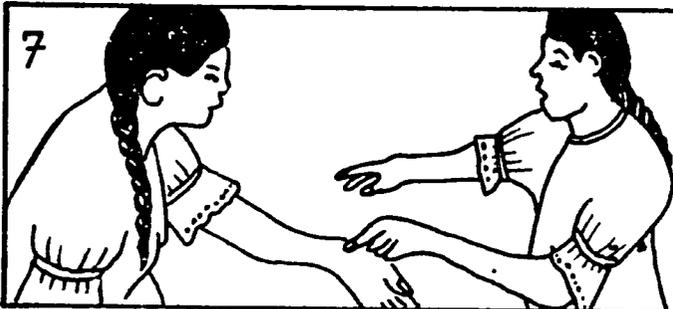
TOS : averiguar si es reciente o si ya hace mucho tiempo que lo tiene. Si es de mas de 15 días enviarla a la clínica de los pulmones o a consulta médica.

6



senos (pechos): ver el tamaño, ver la areola, su color, aconsejar a la madre sobre cómo debe limpiárselos y que no es necesario que se los lave con jabón ya que puede usar solo agua. Debe secarlos bien y utilizar un buen sostén, también es importante ver como son los pezones, si no estan invertidos, de ser así, enseñarle a la madre que debe pellizcarlos y darle masajes con los dedos, estirándolos y tratando de formar el pezón para que pueda dar de mamar al nacer el niño.

7



Examinar Piernas y Brazos: para buscar cualquier anomalía, como hinchazón en tobillos y dedos, granos, várices.

La señora tiene várices cuando tiene sus venas muy saltadas y se queja de dolor. Para evitar más complicaciones recomendar a la señora que se acueste durante 15 minutos con los pies en alto, 3 veces al día.

8 Mirar el abdomen sin tocarlo; si el embarazo apenas empieza no habrá ningún cambio, si tiene mas de 5 meses habrá aumento de tamaño y podrían verse movimientos fetales y tiene forma de huevo.

- Si la forma del abdomen es diferente podría ocurrir lo siguiente:
- si es largo y estrecho puede pensar que el feto tiene las piernas estiradas.
 - si hay aumento total de la matriz hacia lo largo y lo ancho se puede pensar en gemelos.
 - si el aumento es hacia los lados sospechar posición transversa.

Si el vientre se ha puesto grande y redondo y la piel es delgada, sospechar mucha agua. Esto sucede mas en señoras que han tenido muchos hijos. En las primigrávidas podría indicar que la cabeza del feto no puede pasar por la pelvis.



9 Palpar o Tocar el Abdomen (Palpación)

Después de mirar el abdomen se palpa o se toca para averiguar el tiempo de embarazo para ver en que posición está el niño o sea que parte del cuerpo tiene cerca de lo pelvis. La pelvis es el hueso por donde sale el niño al nacer. Lo normal, es que cerca de la pelvis está la cabecita, pero a veces tiene el hombro, las nalgas o piés; en estos casos es peligroso para la madre y el niño.



9-a



Para palpar o tocar el abdomen hay que hacer y recordar lo siguiente: Mandar a la señora a orinar, para que no esté aumentando el tamaño del abdomen.

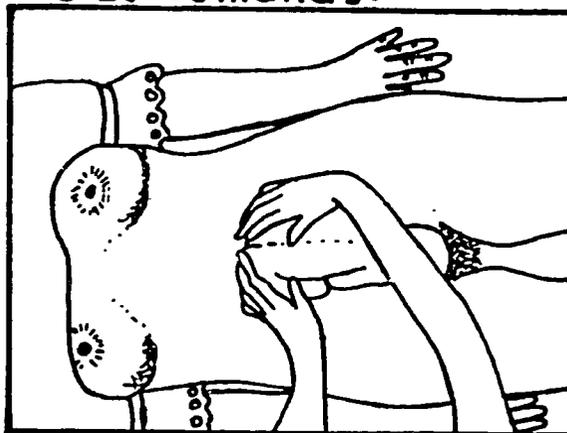
9-b



Acostar a la señora con las rodillas dobladas para que afloje los músculos del vientre.



Maniobras de Leopold: 0 pasos para ver cómo está colocado el niño en el útero materno. Estas maniobras son 4 y se pueden empezar a hacer a los 6 meses de embarazo o 28 semanas.

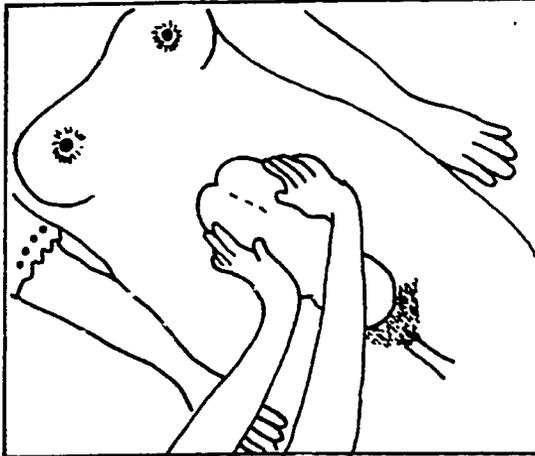


1— Primera Maniobra:

Se hace para averiguar que partes del feto están arriba en el fondo del útero.

Para hacer la primera maniobra recuerde lo siguiente:

1. Acueste a la señora con los pies estirados, sin almohada.
2. Pórese frente y al lado derecho de la señora
3. Extienda sus manos en la parte alta del abdomen de la señora, procurando dibujar al niño.

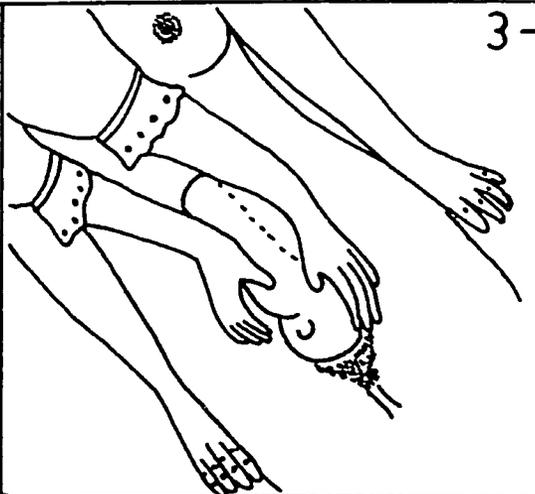


2—Segunda Maniobra:

Se hace buscando los lados del útero y encontrar el dorso (espalda) y pequeñas partes (brazos y piernas) del niño.

Para la segunda maniobra recuerde lo siguiente:

1. Manténgase de pie frente y al lado derecho de la señora
2. Hacia los lados del útero baje sus manos despacio y haciendo poca fuerza con la yema de los dedos.
3. De un lado sentirá varias partes abultadas, algo separadas entre sí que son los brazos y los pies.
4. Del otro lado sentirá un bulto grande y parejo que es la espalda del niño.



3—Tercera Maniobra:

Se hace para encontrar la cabeza del niño. Se llama de "peloteo" porque al empujar la cabeza rebota. Se recomienda hacerlo con una mano; pero la práctica ha enseñado que hacerlo con las dos manos causa menos dolor a la madre.

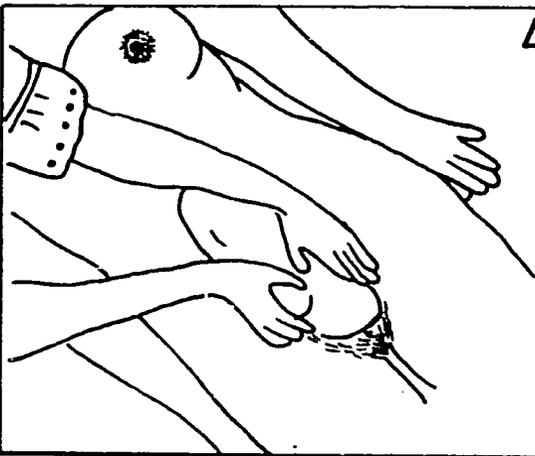
Para la tercera maniobra haga lo siguiente:

Hágalo con cuidado, sin mucha fuerza, para evitar dolor.

Manténgase frente y de lado derecho de la señora.

Con una o dos manos, toque la parte baja del abdomen de la señora. Encontrará un bulto duro, redondo como pelota, que es la cabeza del niño.

Si no encuentra el bulto duro y redondo allí, es que está en otro lugar.



4—Cuarta Maniobra:

Se hace para saber cuánto ha bajado la cabeza del niño a la pelvis.

Para la cuarta maniobra haga lo siguiente:

- Dando la espalda a la cara de la madre, haga presión con los dedos de ambas manos, una a cada lado de la cabeza en la cavidad pélvica.
- Póngase al lado derecho de la madre.
- Para poder ver el grado de encajamiento, compruebe:
 - Si la cabeza del feto ya no pelotea es porque ya está bien encajado.
 - Si la cabeza del feto está móvil es porque no ha encajado.

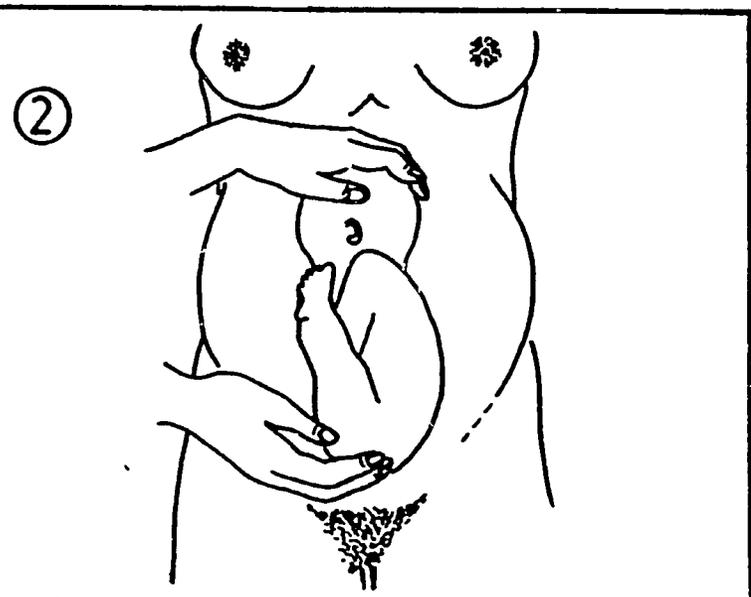
PRESENTACION: de acuerdo a la parte del feto que se coloca en la pelvis (parte por donde pasa el feto al nacer); hay distintas presentaciones.



Niño en Presentación Cefálica.

Si el niño viene de cabeza se llama presentación Cefálica.

Generalmente la cabeza se halla doblado para adelante, de manera que la barbilla del niño descansa sobre su pecho, ocurre en casi el 99% de los casos. Es una presentación normal.



Niño en Presentación Podálica o de Nalgas.

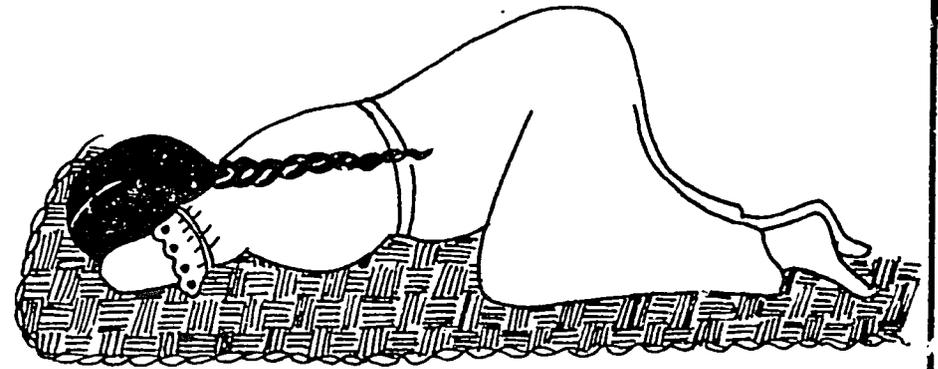
Si el niño viene de nalgas, se llama Presentación Podálica. Una presentación podálica no sucede al final del embarazo, debido a que todos los fetos se voltean antes del séptimo mes. La presentación nalgas sucede durante los primeros meses en casi la mitad de los niños. Hay varias posiciones de nalgas, pero la más común es la siguiente: Las piernas del niño dobladas sobre el abdomen con las rodillas rectas de manera que los dedos de los pies tocan la cara y las nalgas se presentan sobre la pelvis. Si ocurre esto, aconsejar a la madre que haga los ejercicios que están en la página siguiente, si no se voltea el niño y la madre tiene ya 9 meses de embarazo aconsejarle que vaya al hospital cuando empiezan los dolores.



Presentación Transversa o de Hombros

Si el niño viene de hombros o atravesado se llama Presentación Transversa o de Hombros, si la señora tiene 6, 7 u 8 meses de embarazo, aconsejarle que trate de cambiar la posición del niño con los ejercicios que están al lado. Si ya no se voltea el niño o la madre tiene 9 meses ya de embarazo, aconsejarle que vaya al hospital cuando empiezan los dolores ya que tiene que operarse, si no se puede morir ella o el niño.

En estos casos "muchas veces la matriz se extiende mas a los lados y no tanto por delante". Al palpar la matriz, la cabeza no se encuentra por abajo, si no a un lado. Esta es una presentación muy peligrosa para la vida del niño y la madre si no se "OPERA"

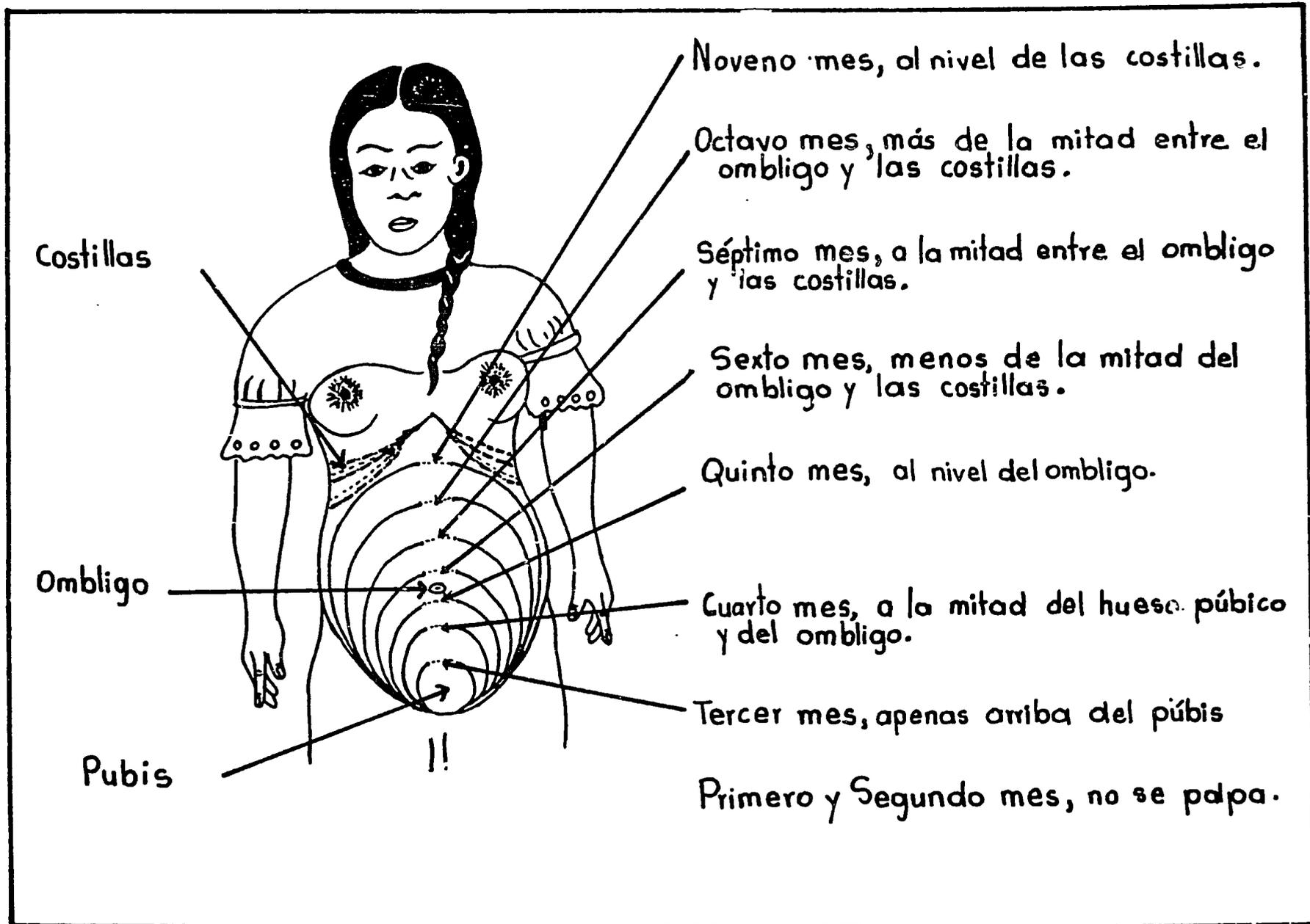


Como Puede Cambiarse la Presentación del Niño que viene sentado y Transversa

1. Entre los niños que nacen diariamente, 95 vienen de cabeza, es el nacimiento normal, más fácil para la madre y seguro para el niño.
2. Cuando descubrimos palpando la matriz en el séptimo mes que un niño viene sentado (de nalgas o atravesado) debemos aconsejar a la madre así: Ponerse de rodillas e inclinarse con la cabeza sobre los brazos en el suelo, quedarse en esta posición por 10 minutos 2 veces al día.
 - Es bueno tener una hora fija para hacer el ejercicio para no olvidarse: 10 minutos antes de almuerzo y 10 minutos antes de cena.
 - Hacer esto todos los días, hasta que el niño se ponga cabeza abajo. Por lo menos 4 a 6 semanas.
 - Es la misma posición que dá alivio al dolor causado por almorranas o várices del ano durante el embarazo.
 - Si se prefiere se puede lograr lo mismo acostado con las caderas elevadas como una cuarta y media más alta que la cabeza.

La mayoría de los niños se voltean cuando uno es fiel a los ejercicios.

Calculando la Edad del Embarazo: según la altura que alcanza el útero o matriz al palpar (tocar) el vientre de la madre; se calcula la edad del embarazo así:



Calculando la fecha de nacimiento de un niño.

Preguntar a la embarazada la fecha que vio la última regla; a esta fecha que nos diga: _____ se le suman 9 meses y a esta fecha se le suman 7 días. el resultado es la fecha probable del parto.
Ejemplo:

Primer día de la última regla	más nueve meses	más siete días (esta es la fecha probable)
6 de mayo de 1982	6 de febrero	13 de febrero de 1983
26 de febrero 1982	26 de noviembre	3 de diciembre
13 de agosto 1982		
2 de diciembre de 1982		
29 de julio de 1983		
7 de Septiembre de 1983		
12 de marzo de 1983		

El año 1982:
enero- febrero- marzo- abril - mayo - junio- julio- agosto- septiembre- octubre- noviembre
diciembre.

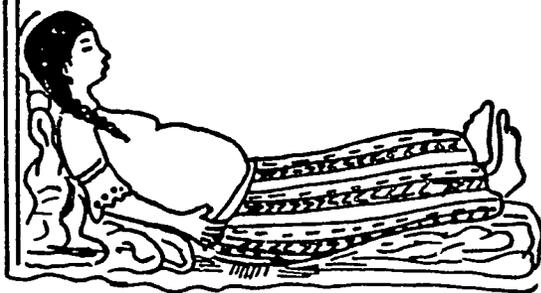
El otro año: 1983.
enero- febrero- marzo- abril- mayo- junio- julio- agosto- septiembre- octubre- noviembre- diciembre

26 Cuidados de la Madre Durante el Embarazo



Es muy importante que la mujer embarazada se considere una persona valiosa, porque el embarazo es una etapa especialmente significativa y emocional en la vida de toda mujer. Es por ello que debe poner todo su esfuerzo en verse y sentirse bien, y disfrutar de su experiencia al máximo. Debe estar muy clara de su sensibilidad y saberla usar, no debe hacerse la sufrida, usando su estado para tener ventajas o demasiadas atenciones de los demás.

Debe de tratar de alcanzar la salud mental a través de tener ocupada su mente por ejemplo: con alguna lectura, tejer lana, hacer bordado y caminar bastante.



Es importante orientarla sobre la conducta que debe seguir, indicarle lo que puede y no puede hacer, por ejemplo es frecuente que se canse con más facilidad que antes y debe descansar más tiempo de lo acostumbrado es mejor si lo hace acostada.



Es recomendable que se lave el pelo las veces que sea necesario para evitar parásitos (piojos y caspa). También es aconsejable peinarse todos los días y lavar el peine, especialmente cuando varios de la familia usan el mismo peine.

-Aseo General

Es mentira que la mujer embarazada no puede bañarse. Al contrario si se puede bañar todos los días es mejor, si no es posible, entonces 3 ó 4 veces por semana.

Al bañarse se cambiará de ropa. Después de bañarse o cambiarse de ropa se sentirá activa, contenta y animada a hacer el aseo del resto de su casa, especialmente de la cama para que duerma en ella cómoda y tranquilamente.

Al bañarse en los ríos, es mejor no sentarse en una reposadera sino echarse el agua con palangana para que no le entre microbios por sus partes. Las familias que tienen temascal, es recomendable mantenerlo limpio y sin cosas viejas allí guardadas.



-Cuidado con los Pezones o Punta de los Pechos.

Es muy importante que la señora aproveche el baño para la limpieza de los pezones y desde el séptimo mes del embarazo. procure formarse el pezón y tener así menos problemas al dar de mamar, especialmente cuando es el primer embarazo porque es posible que tenga los pezones "invertidos" o sea hacia adentro, entonces hay que formarlos jalando la punta con los dedos para darles forma.



-Ejercicios:

Es muy importante orientar a la señora sobre lo que es un embarazo, ya que algunas mujeres piensan que es una enfermedad y que por eso ya no pueden hacer nada ni deben trabajar.

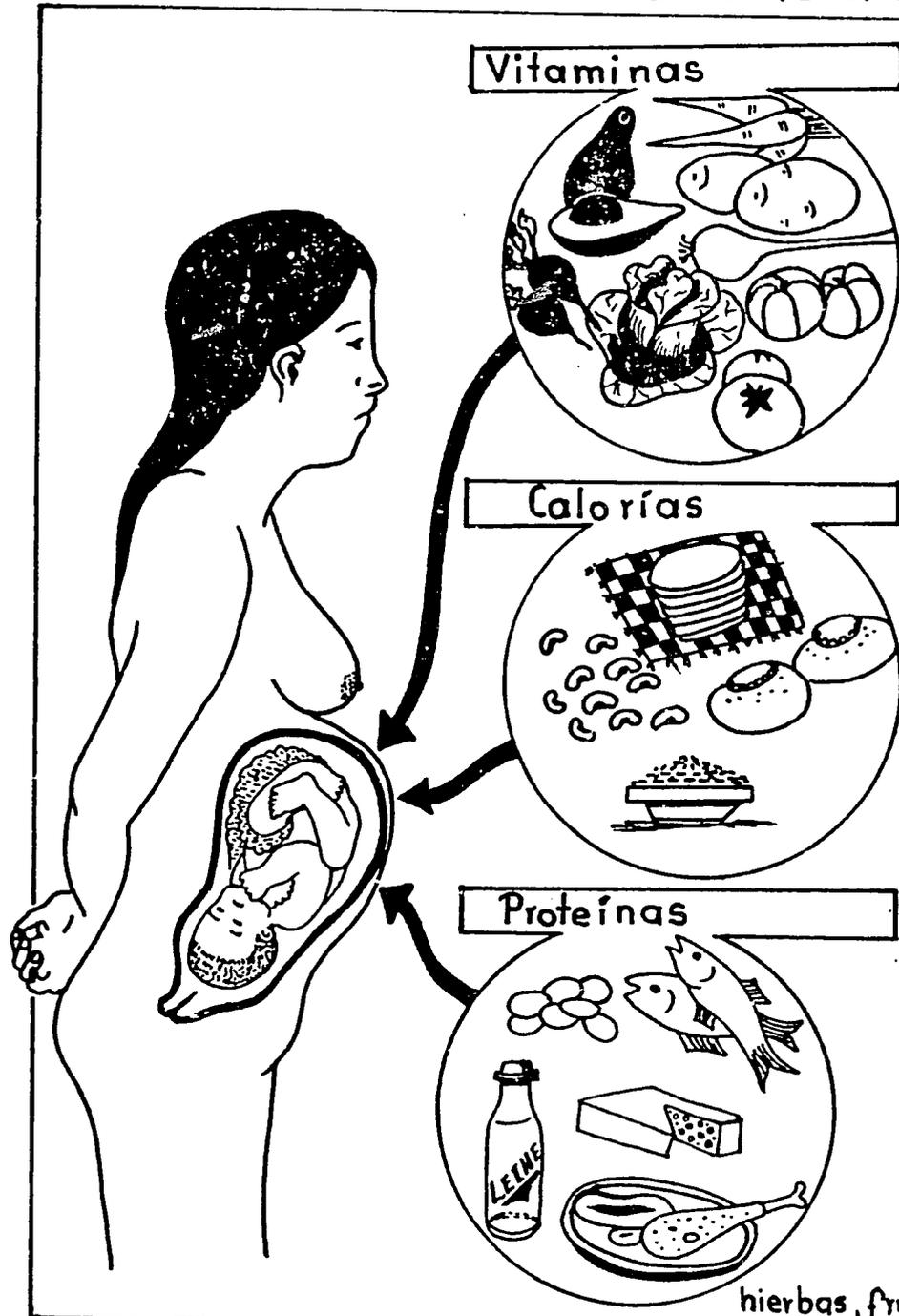
Es importante que la madre continúe haciendo sus tareas domésticas, ya que algunas le ayudan y le sirven de ejercicio.



-No levantar cosas pesadas

Tampoco se debe de abusar, porque hay tareas que la mujer embarazada no podrá hacer como los hacía antes cuando no estaba embarazada, ya que puede causarle problemas. Como ejemplo: transportar o levantar cosas pesadas.



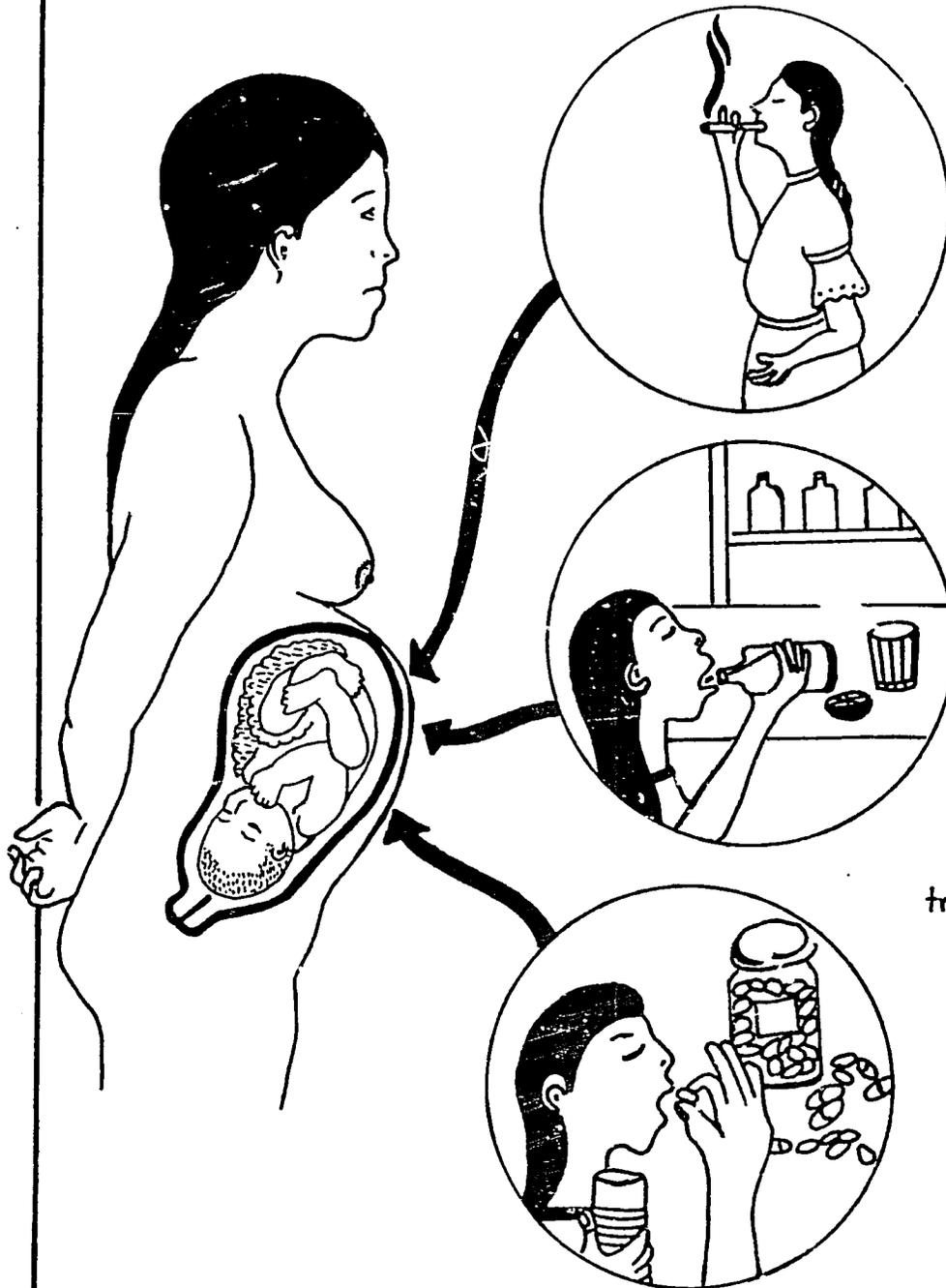


Alimentación de la Madre o lo que Necesita Comer:

Alimentarse bien no quiere decir comer mucho, algunas ideas que hay que recordar son:

1. Cuando hay un embarazo el cuerpo no sólo necesita más cantidad de alimentos, si no que también variedad de alimentos y muchos líquidos, si fuera posible leche.
2. Muchas mujeres toman vitaminas y píldoras con hierro para asegurarse que están obteniendo lo que necesitan para un buen embarazo, pero esto solo puede ser una ayuda "pero no puede reemplazar a la alimentación" "Lo más importante es saber alimentarse".
3. Nuestra comida debe tener alimentos de los tres grupos básicos: Proteínas, calorías y vitaminas.
4. Cuando la señora embarazada no tiene ganas de comer es necesario que comprenda que debe comer todo lo que pueda aunque sea en tiempos no acostumbrados (desayuno, cena etc).
5. Cuando la señora embarazada no tiene ganas de comer, las personas cercanas le animen y le den comidas que no siempre come, como: frutas, pan, frescos de frutas, tortillas tostadas.
6. Hay que animar a la embarazada a comer las hierbas, frutas que crece en su comunidad, que coma más frijol de lo acostumbrado, que tome atol de maiz, haba etc.

Debe Evitar: tomar trago, fumar cigarro y medicina innecesaria



La salud y el crecimiento del niño durante el embarazo "depende en su mayoría de lo que la madre come, ya que todo es pasado a través de la placenta al niño.

- Tomar trago o cusha seguido, no es bueno ni para la madre ni para el niño, lo mismo sucede con el cigarro, según estudios que se han hecho.
- Antes de tomar cualquier medicina la madre deberá informarse de los efectos que tal medicina podría ocasionar en el crecimiento del niño.
- Si es necesario tomar medicina es importante que avise de su estado de embarazo a la persona que le recete para ver si no es necesario hacer algún cambio.
- Usted puede vivir sin los cigarros, sin el trago y sin medicinas que no ha recetado algún médico durante su embarazo y mientras dá de mamar al niño, porque varios problemas de salud pueden venir por estas cosas que no son necesarias.

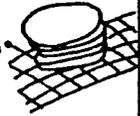
30 Molestias Normales Durante el Embarazo

Asco, náuseas o vómitos en los primeros 3 meses



Consejos

- Puede ayudarse comiendo alimentos secos como: pan, tortillas tostadas sin café antes de levantarse en la mañana.
- Comer varias veces al día en vez de 3. Puede ser mental.
- Si es por infección en la garganta que haga gárgaras de limón.
- Orientar a la señora que el asco no sigue después de los 3 primeros meses.

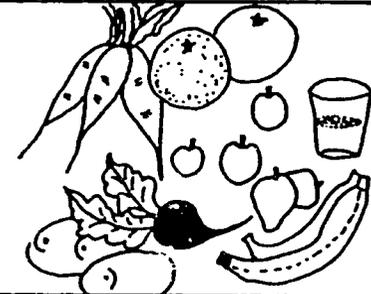


Estreñimiento o dificultad para ensuciar



Le ayuda el comer:

- Frutas y verduras frescas.
- Tomar suficiente líquidos.
- Hacer ejercicios.
- No usar purgante si no es ordenado por un médico.
- Tomar agua en ayunas.



Ardores (acidéz) en el estómago.



- Comer por poquito pero varias veces al día.
- No comer cosas con muchos irritantes como: grasas, chile, café etc.
- Tomar un antiácido.
- Tomar leche.



Dolor de cintura o de espalda.

- Puede ser por infección urinaria. Esta se asocia muchas veces con baja presión.

Las personas se desmayan de dolor.

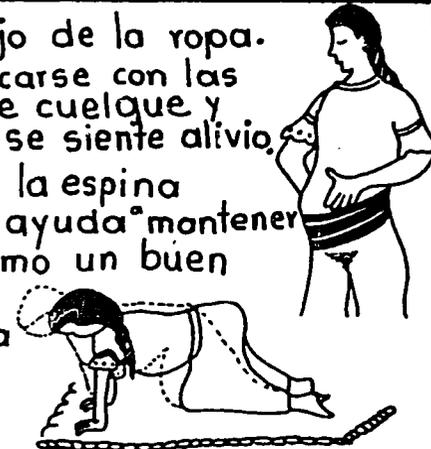


Usar faja para sostener la matriz debajo de la ropa.

Para el dolor de la espalda puede: hincarse con las manos en el suelo para que el vientre cuelgue y el niño se acomode, se reparte el peso y se siente alivio.

Entre las dos manos se balancea sobre la espina dorsal (columna) sin forzarse. También ayuda mantener una buena postura del cuerpo así como un buen masaje en la espalda.

Si hay infección urinaria, dar ampicilina 3 veces al día por 15 días 500 mg. Tomar 2 o 3 litros de líquido.



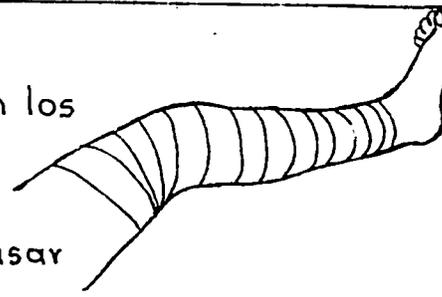
Enfermedades que se Presentan Durante el Embarazo:

Várices: (venas inchadas) en las piernas.

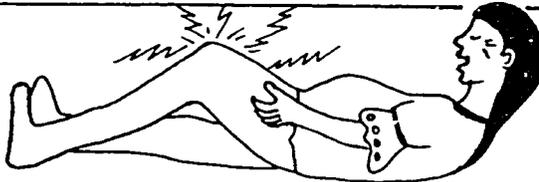


Consejos:

- Descansar varias veces al día con los piés elevados.
- Vendarlas durante el día hasta la rodilla si hay mucho dolor.
- Quitar la venda durante la noche o usar vendas elásticas.



Calambres Frecuentes en las piernas.

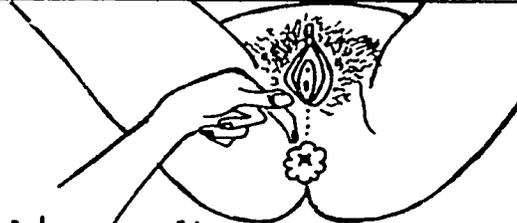


Consejos:

- Se puede hacer presión en la planta de los piés, con las piernas extendidas.
- Un familiar puede sobar las piernas con pomada balsámica.
- Ponerle lienzos calientes sobre la parte adolorida dos veces al día durante 15 minutos cada vez.

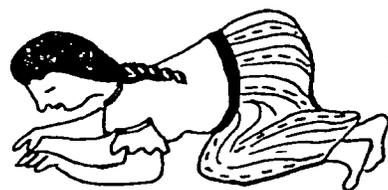


Hemorroides o Almorranas (várices en las venas del ano)



Consejos:

- Ponerse lienzos de agua fría o sal inglesa
- Tomar esta posición para descansar.
- Comer bastantes verduras y frutas.
- Tomar muchos líquidos para ensuavecer el popó.



Hinchazón de los piés (si es por la tarde es normal). Si amanece con los piés hinchados avisar al médico.

- Si la hinchazón es permanente puede ser por desnutrición.

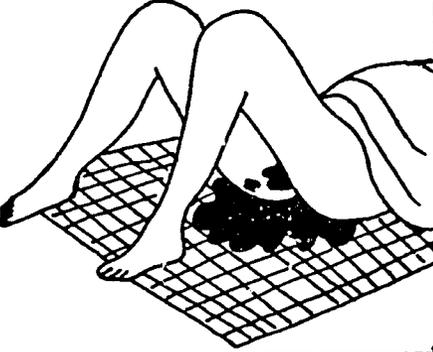


Consejos:

- Si es por la tarde, descansar varias veces al día con los piés en alto.
- Si amanece con la hinchazón, llevarla al médico.
- Comer huevo, carne, pescado y verduras
- Tomar multivitaminas.



Peligros Durante el Embarazo

<p>Hemorragia; por más de un día o salida de cualquier flujo o líquido. Durante los primeros dos o cinco meses.</p>		<p>Puede ser Amenaza de "Aborto"; hacer lo siguiente:</p> <ul style="list-style-type: none"> - Reposo absoluto en cama, hasta que ya no haya salida de sangre. - Llevarla al médico. - Si no hay médico darle Fenobarbital 32 miligramos una tableta pequeña 3 veces al día. - Si no deja de sangrar se trata como parto y se lleva al hospital.
<p>Vómitos de día y de noche que tarda más de 3 meses. Retorcijones cerca de la boca del estómago.</p>		<p>Hacer lo siguiente:</p> <ul style="list-style-type: none"> - Como es muy fuerte, ir al médico o al centro de salud. - Ver que la madre se alimente. - Vigilar por deshidratación. - Vigilar que no resulte ser intoxicación del embarazo, de ser así repórtelo inmediatamente.
<ul style="list-style-type: none"> - Dolor moderado de la cabeza por falta de vitaminas y alimentos. - Dolor muy fuerte de cabeza - Calambres, atarantamiento en los últimos 3 meses de embarazo. - Puede ser signo de aborto espontaneo por muerte fetal o por pre-eclampsia. 		<p>Hacer lo siguiente:</p> <ul style="list-style-type: none"> - Como es muy fuerte y no es normal llevarla al médico o al centro de salud de inmediato, puede ser pre-eclampsia, esto causa la muerte del niño y de la madre. - La embarazada no debe tomar aspirina para el dolor. Mejor usar Acetaminofen. - Tomar multivitaminas, 1 tableta cada día por lo menos por 1 mes. - Mejorar la dieta.

Peligros que Necesitan Atención Médica Inmediata En los 3 Ultimos Meses

Toxemia o Intoxicación del Embarazo.

- Orina muy poco al día.
- Siente muchas molestias al orinar.
- La orina puede ser de un color muy subido.



Qué hacer:

si se hincha todo el cuerpo llevarla al médico o centro de salud.

- Aumenta la presión sanguínea.
- Puede sentir mareos y desmayos fuertes.
- Puede aumentar muy rápido de peso.



- De ser posible control constante de la presión de la sangre.

- Explicar a la embarazada que todos éstos síntomas indican un veneno, el cual puede causarle la muerte.

- Hinchazón de los tobillos, los pies, las manos, los párpados y la cara.

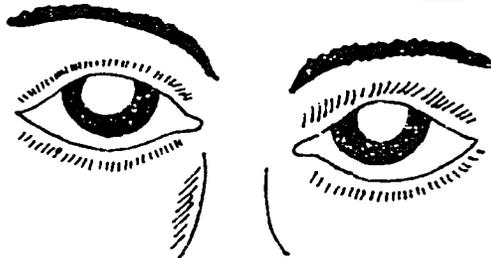


Explicar a la madre que con cualquiera de éstos síntomas ella puede convulsionar y morir.

- La partera o el promotor pueden evitar esto y salvar la vida de la madre y el niño si se la llevan de inmediato al médico.

Transtornos de la vista.

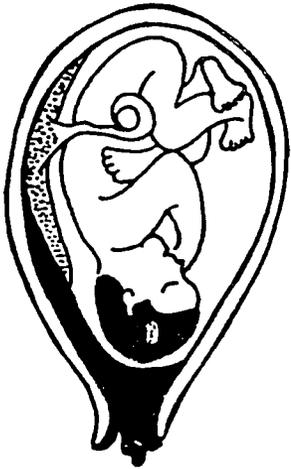
- Mancha ante los ojo
- oscurecimiento de la vista nublada o borrosa



Por esta señal junto con las de arriba, se hacen necesario llevar a la señora al médico inmediatamente.

Peligros que Necesitan Atención Médica Inmediata en los 3 Ultimos Meses de Embarazo

Desprendimiento Prematuro de Placenta



Es la separación de una parte o de toda la placenta de su lugar de Implantación o donde se pegó, esto es antes de que nazca el niño. Puede producir hemorragia de la placenta total o parcialmente desprendida, o permanecer oculta la sangre. La madre siente dolor, desmayos, el útero en lugar de encontrarse blando se siente duro al tocar el abdomen.

Si está escondida la hemorragia se junta en el fondo de la matriz y no se ve, además de que la señora siente fuerte dolor de abdomen, ésta se pone cada vez más duro y tieso, el pulso es rápido y débil, la señora se pone pálida, se pone desesperada, suda frío y puede desmayarse.

Consejos y Tratamiento



- Llevarla al hospital inmediatamente.
- Colocarla en la camilla, con la cadera más alta que la cabeza y los pies cruzados.
- Llevar líquido para que tome la señora en el camino.

Desprendimiento Prematuro de Placenta "con sangre oculta"

Placenta Previa:



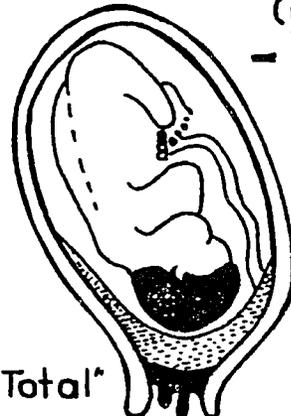
Hay sangrado vaginal, sin dolor, ni calentura.
Maneras:

Placenta Previa Parcial:
sólo se encuentra cubriendo una parte de la abertura cervical.

Placenta Previa Total:
Es la que se encuentra cubriendo toda la abertura cervical de la parte más baja del útero.

Consejos y Tratamiento

- Enviarla inmediatamente al hospital.
- Acomodarla en camilla con la cadera elevada y los pies cruzados.
- Llevar líquidos para que la madre tome en el camino.
- No poner lavados porque aumenta la hemorragia.
- No examinar vaginalmente a la paciente (no meter la mano).



- Toda paciente que sangra aunque sea (gotas o manchas) en la última mitad del embarazo, hay que llevarla de inmediato al hospital para ser atendida por un médico.

"Total"

Parto: Milagro de la vida!

Comienza cuando el embarazo termina y cuando empiezan los dolores; termina cuando nace la compañera del niño o Placenta. Todo este tiempo se llama también Trabajo de Parto.

El trabajo de Parto se divide en tres partes o períodos llamados:

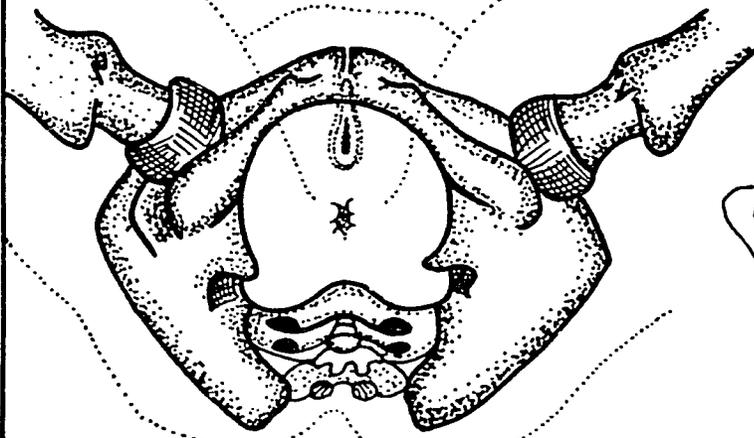
1. Primer Período
2. Segundo Período
3. Tercer Período

Primer Período:

Normalmente en las primíparas (primer niño) tarda de 12 a 24 horas y en las múltiparas (varios hijos) de 8 a 12 horas. En éste período sale moco por la vagina que viene de la orilla del útero o cérvix, donde sirvió de tapón, es de color blanco-rosa, si trae sangre viva es anormal y hay que buscar ayuda médica, si se traslada a la señora hay que llevarla acostada y con las caderas levantadas.

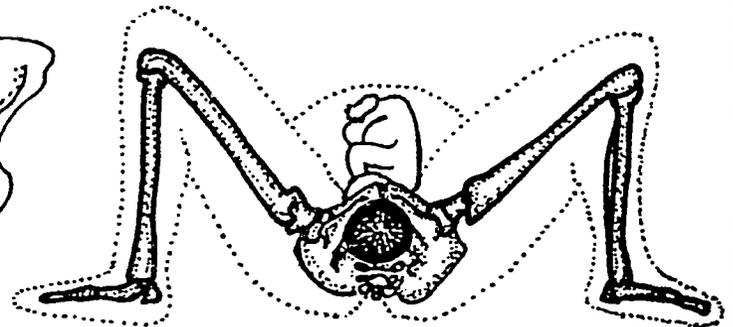
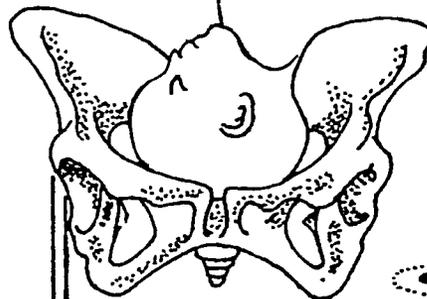
Este período comienza con las contracciones o dolores; hay contracciones falsas y contracciones verdaderas, no hay que confundirlas. Las falsas son ensayos que hace la matriz en el último mes de embarazo, es pareja la fuerza del dolor y la tardanza cada vez que se repiten; el tiempo entre dolor y dolor es disparejo. En cambio en el verdadero se repiten a tiempo parejo y va disminuyendo entre dolor y dolor, hasta llegar a 3 contracciones en 10 minutos; cada vez tarda más, cada vez duelen más.

Pelvis: hueso por donde pasa el niño para poder nacer y salir al mundo exterior

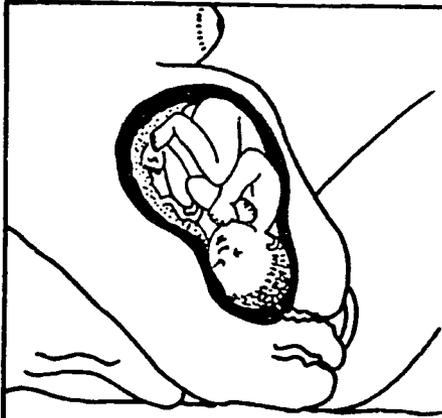


Encajamiento del Niño:

quiere decir, entrada de la cabeza del niño a la pelvis. En primíparas sucede 2 semanas antes del parto, en múltiparas sucede al comenzar las contracciones o dolores.



Parto Normal



Primer Período: comienza con los primeros dolores y termina con la dilatación completa del cuello del útero. Decimos que hay dilatación completa cuando el cuello tiene 10 centímetros o más de diámetro.

1. Decimos que ha comenzado el primer período cuando empieza a dilatarse o abrirse el cuello del útero; por el poder y las fuerzas de las contracciones el niño es empujado contra el útero para poder salir.
2. Al principio las contracciones o dolores comienzan como retorcijones rápidos en la parte baja de la espalda, son suaves, cortos y corren hacia adelante.
3. Conforme va avanzando el trabajo de parto, los dolores son más fuertes, más largos, y vienen seguidos.
4. La señora debe respirar profundo cuando vienen los dolores.
5. No debe pujar.

Segundo Período: comienza con la dilatación completa del cuello, 10 centímetros o más de diámetro y termina con el nacimiento del recién nacido.

→ Se rompe la fuente o bolsa de las aguas (el líquido en el cual ha estado el niño durante los nueve meses de embarazo). No es ninguna señal para empezar a pujar, porque otras veces se rompe con 4 o 5 centímetros de dilatación y otras veces se rompe cuando ya va a salir el niño.

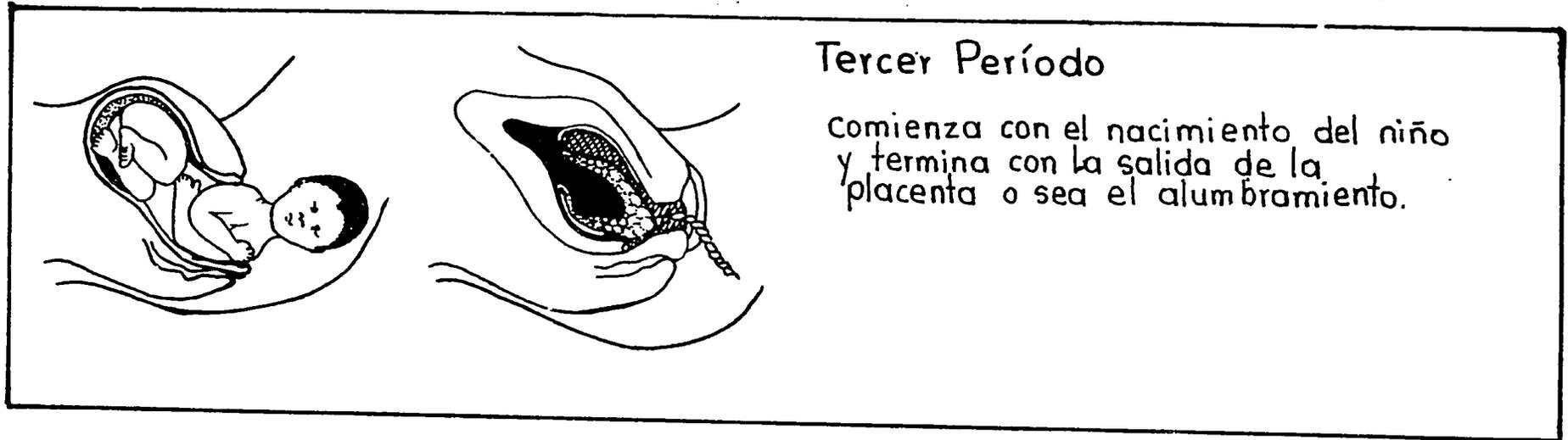


→ Unas veces la fuente se rompe y paran las contracciones, ya no sigue el trabajo del parto. Se puede esperar hasta 24 horas si no hay dolor.

- Para evitar una infección de la matriz y del feto, se puede dar 500 miligramos de ampicilina cada 8 horas después de haberse roto la fuente si el trabajo de parto no continúa.
- Cuando ya se ha roto la bolsa no se debe introducir la mano en la vagina, evitando así llevar una infección a la matriz.
- Las contracciones o dolores han hecho su trabajo, han ayudado a abrir el cuello uterino completamente (10 centímetros) el niño está listo para abandonar su nido y salir a conocer el mundo exterior.
- Cuando el cuello uterino está completamente abierto la señora tiene estas señales:

- ganas de hacer fuerza.
- Empieza a temblar.
- Los dolores vienen más fuertes y seguidos.

- Puede arrojar.
- Siente que va a morir.
- ganas de hacer popó.



Tercer Período

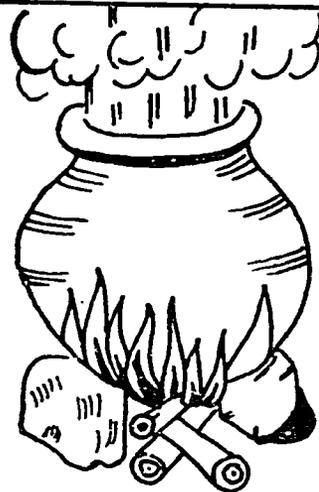
comienza con el nacimiento del niño y termina con la salida de la placenta o sea el alumbramiento.

Primer Período del Parto: lo que hace la madre y los familiares.

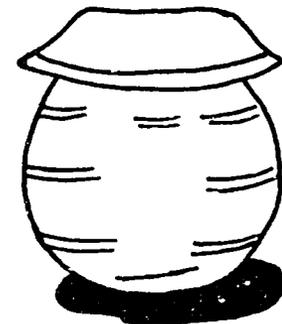


Preparan agua para uso de la comadrona.

- Dejar reposar el agua para que se asiente la basura suciedades y la tierra.

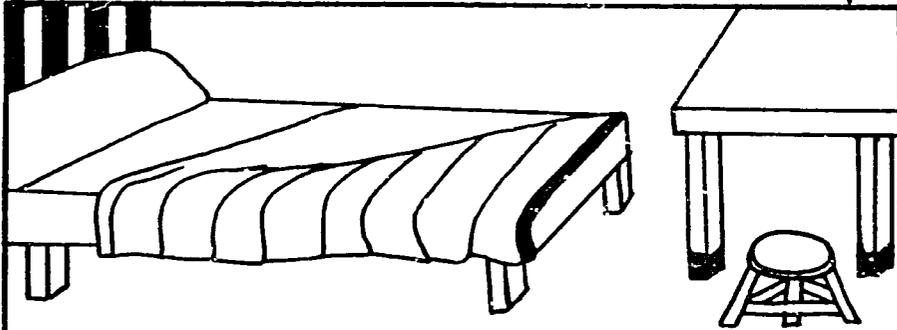


- Hierven el agua hasta que se mueva fuertemente por 20 minutos.



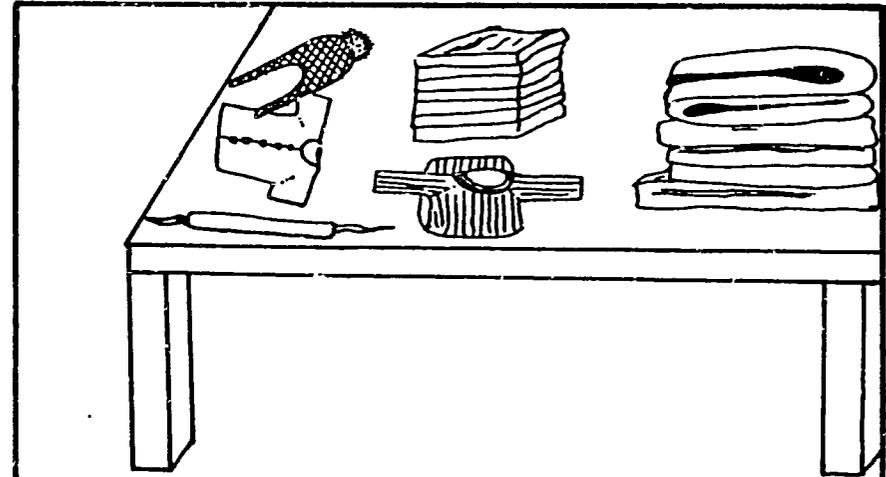
- Dejan la olla tapada mientras el agua hervida se entivia.

38 Primer Período: Lo que hacen los familiares.



Preparar el cuarto y la cama donde va a dar a luz la madre; así:

- limpiar
- Poner suficiente luz
- quitar las cosas que estorban a la madre y comadrona y poner una mesa o silla donde colocar el equipo a utilizarse.

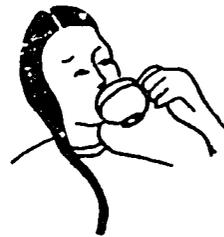


Preparan ropa para el parto y el niño, especialmente trapos de algodón que haya lavado y aseado la madre y ellos.

Primer Período: Lo que hace la madre al principiar los dolores.



La madre se baña y se pone su ropa limpia y floja (bata, camión de manta) y así estar lista y cómoda para el parto.



Toma bastante líquidos por ejemplo: atoles, limonadas, jugos de frutas si es posible alguna sopa, caldo.



Si no aumenta los dolores, que siga haciendo sus oficios como entretenimiento y no estar angustiada.



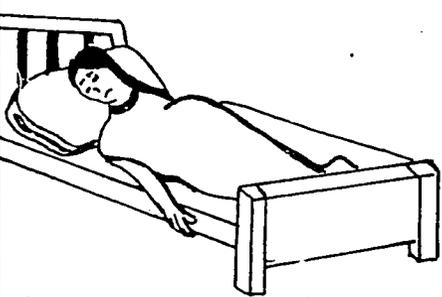
Tratará la madre en lo posible, de orinar, defecar, en este primer período, para dejar más lugar a la salida del niño.



Sigue caminando, aconsejarle cuando tiene contracciones que sus respiraciones las haga despacio y profundas.
Todavía no debe hacer fuerza.



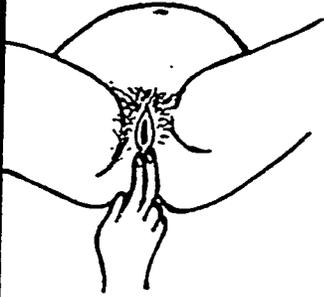
Ella trata de aflojar todo su cuerpo para facilitar el trabajo de la matriz.
Respira hondo y despacio con cada contracción.



Al romperse la bolsa de las aguas, acostarse para evitar que pueda salirse el cordón y entren microbios.



La madre en este momento, no deberá hacer fuerzas, éstas son para el segundo período.

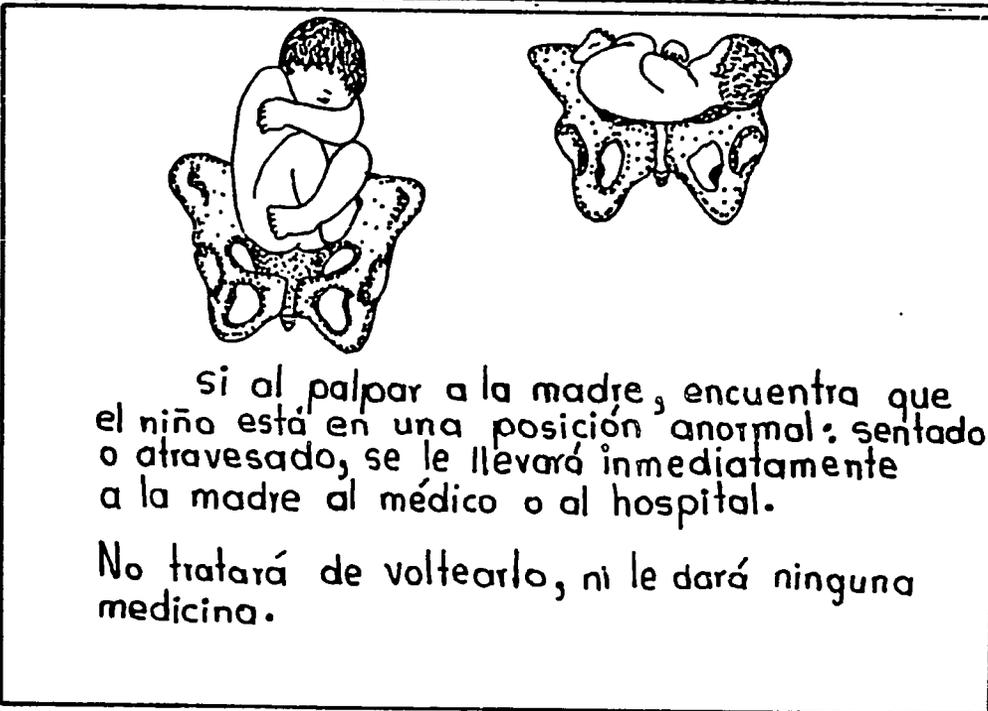
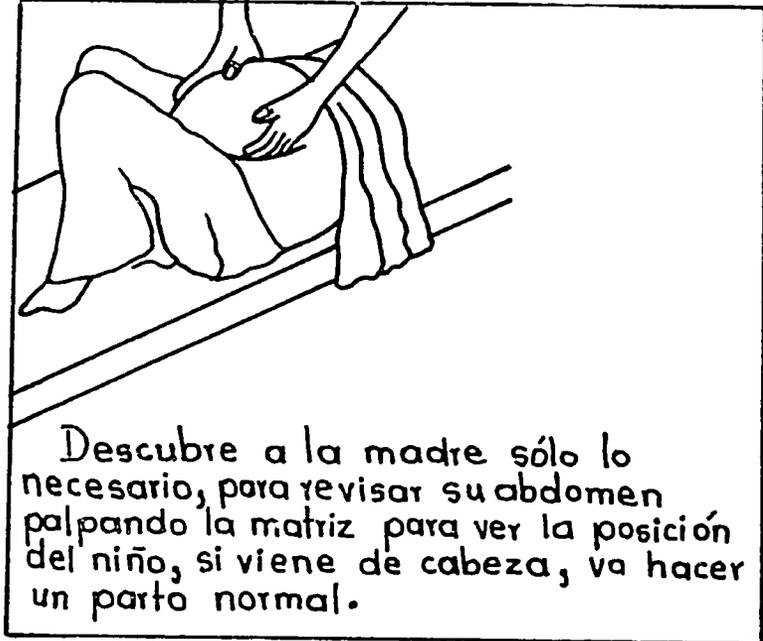


Tampoco debe permitir que la comadrona, promotor o persona que atiende el parto meta los dedos en la vagina (puede causar infección) porque la bolsa de aguas ya se rompió.



La madre ya no debe comer nada.

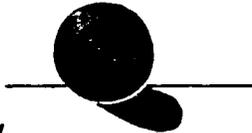
Primer Período: Lo que hace la comadrona o persona que atiende el parto.



Revisa su equipo: para ver si está completo y listo.



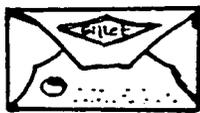
muchos trapos limpios



un jabón para limpieza de sus manos.



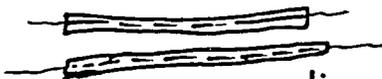
un cepillo limpio para lavarse las manos y uñas.



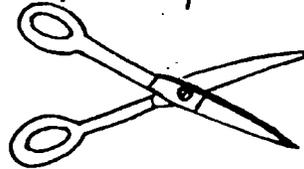
cuando no hay tijeras se usa una hoja nueva de rasurar bien hervida para cortar el cordón.



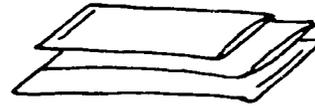
gotas para los ojos del recién nacido.
Argirol (nitrato de plata).



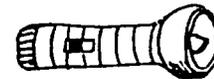
Listones fuertes de trapo limpio, seco.



Tijeras limpias y sin moho hervirlas para poder cortar el cordón.



gasa esterilizadas o parches de tela bien limpios y planchados para tapar el ombligo.



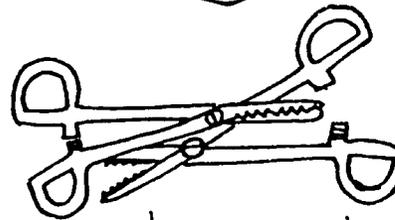
una lámpara o foco de mano, por si no hay buena iluminación.



Fetoscopio de madera, para escuchar los latidos del corazón del niño.



Perilla o bombita para chupar lo que trae el niño en la boca y nariz al nacer.



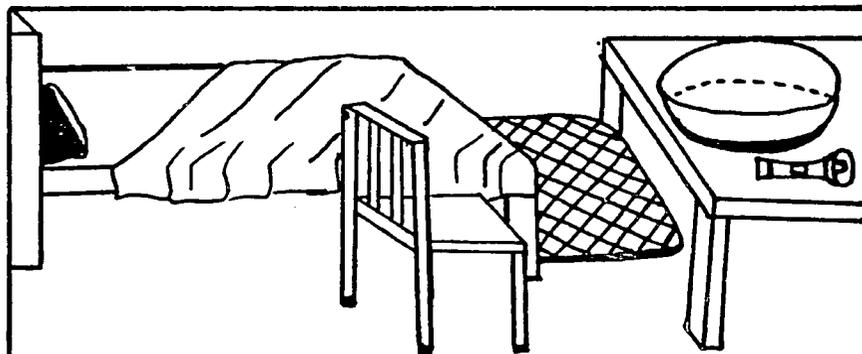
de ser posible 2 pinzas para pinzar el cordón, o para detener alguna hemorragia producida en una vena por un desgarro durante el parto.



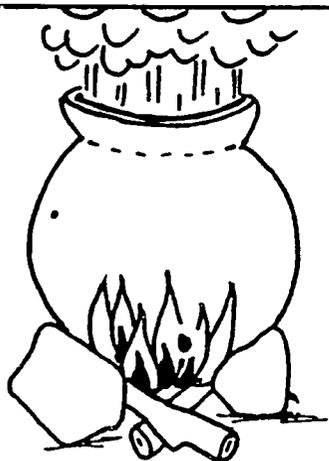
Agujas e hilo estériles para coser alguna rasgadura por si fuera necesario.



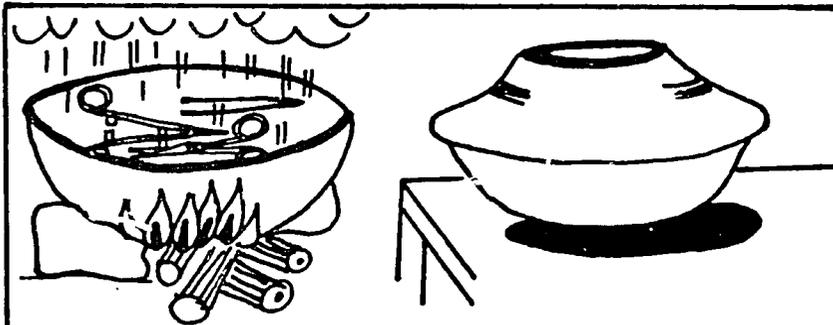
Como es natural la madre estará temerosa, la persona o comadrona que atenderá el parto la colmará, le dará confianza y seguridad, le asegura que todo va a salir bien.



Ve y revisa que la casa esté preparada para el parto:
Prepara el cuarto, la cama donde va a dar a luz la embarazada. Se fijará, de que haya luz y que sea ventilado, de ser posible amplio.



Pide ayuda a los familiares y al esposo para que haya suficiente agua caliente, para los aseos de la madre y las manos de la comadrona. Deberá pedir que se prepare suficiente agua para utilizar después del parto, tanto para el niño como para la madre, ya que los 2 necesitan limpieza.



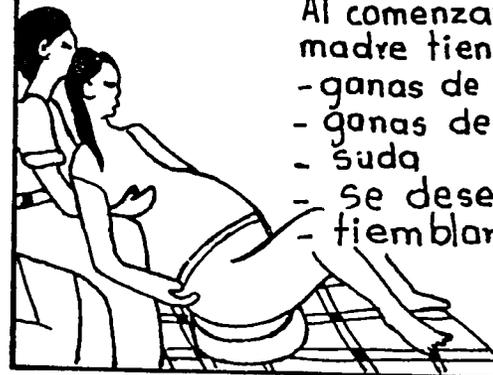
Después de hervir las tijeras o la hoja de rasurar y los trapitos para limpiar la boca del niño al nacer, se guarda en un trasto limpio (hervido).

Segundo Período del Parto:

- Empieza con la dilatación completa del cuello del útero o matriz y termina con el nacimiento del niño.
- En las primigestas tarda de 1 a 3 horas, en multíparas de 5 minutos a 1 hora
- En este período las contracciones o dolores vienen más seguidos, más fuertes y duran más.
- En este período nace el niño, por eso se dice que es el período que Trae al Niño.

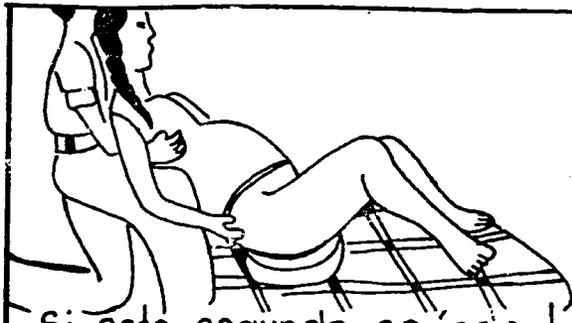


Mejor si está presente el esposo para ayudar a apoyar a la madre.



Al comenzar este período, la madre tiene estas señales:

- ganas de hacer fuerzas
- ganas de hacer popó.
- suda
- se desespera
- tiemblan las piernas.



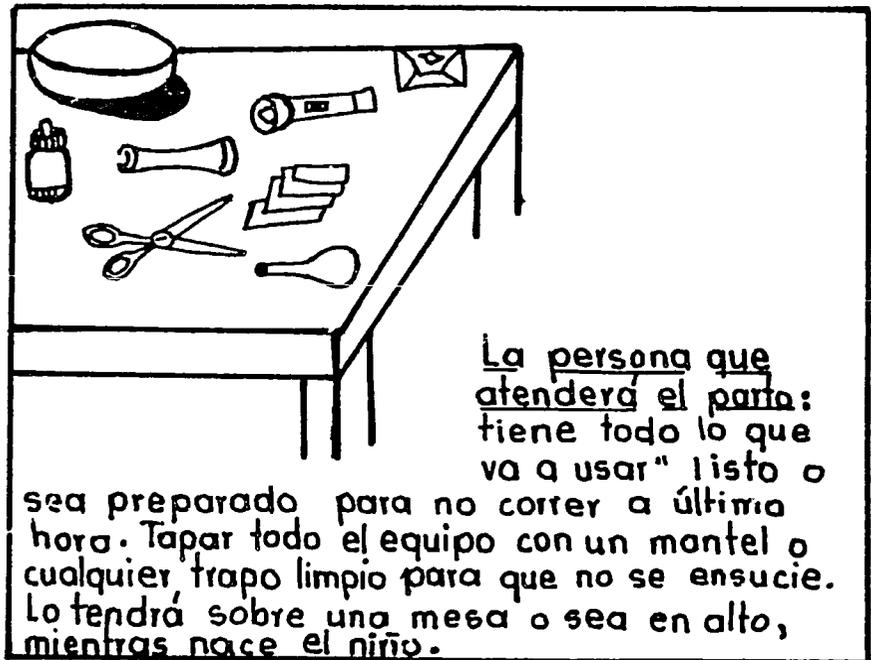
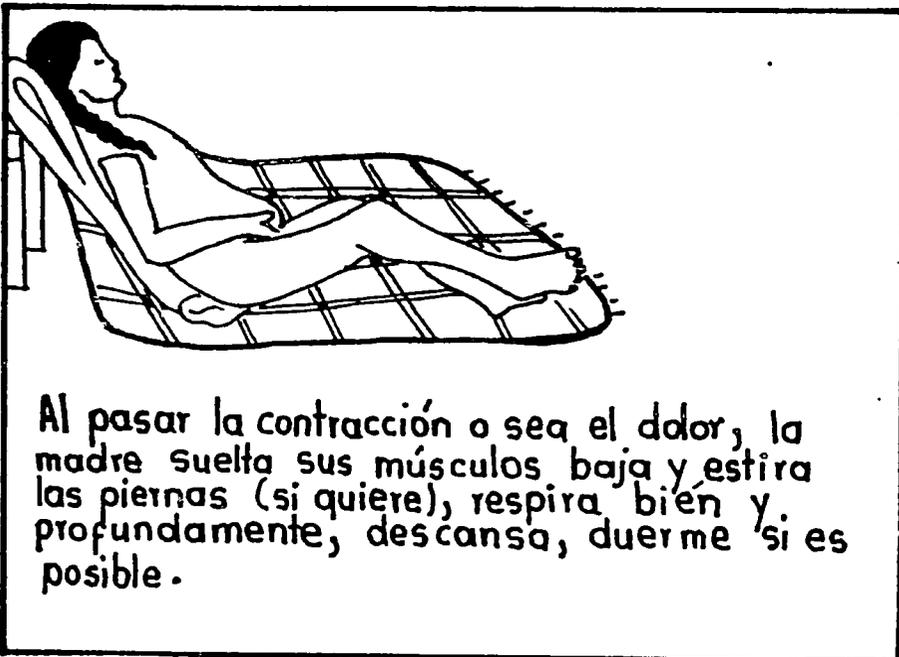
Si este segundo período tarda mucho, la madre debe aprovechar para orinar, así dejará más espacio en su organismo para que el niño pase.

"La madre": escucha a la comadrona, para saber cuando debe de dejar de hacer fuerza y cuándo debe respirar con la boca abierta.

"Piensa en la alegría de tener a su niño, esto le ayuda a aflojar los músculos y traer al niño.

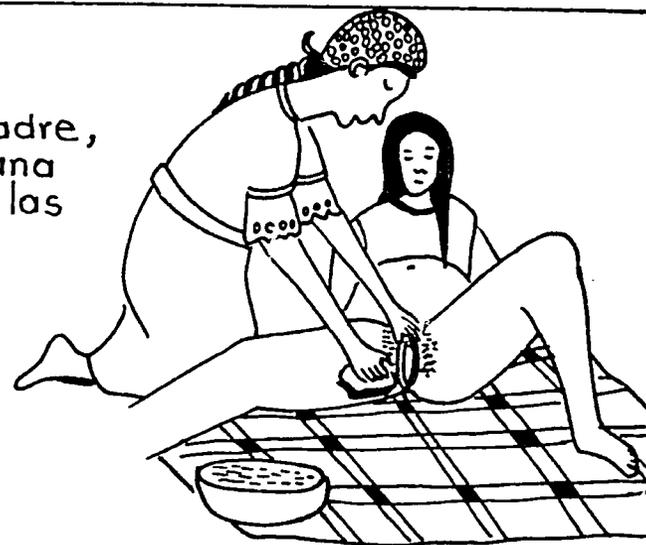


Segundo Período: Lo que hace la madre.

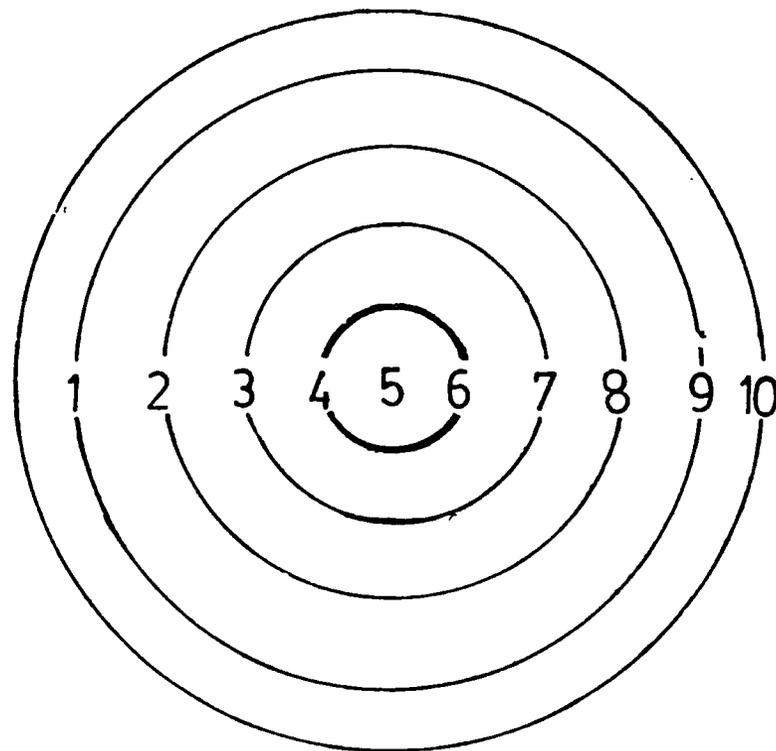
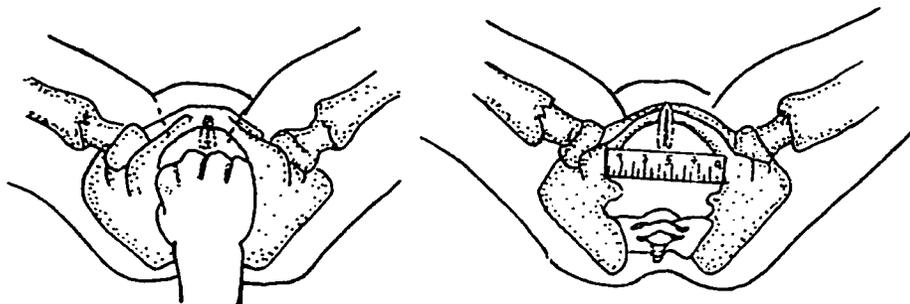


Preparación de la madre: se limpia las partes de la madre, con trapitos limpios, agua y jabón. Para esto puede usar una sábana o trapo con un nylon y colocarlo por debajo de las nalgas de la señora, para que allí caiga el agua.

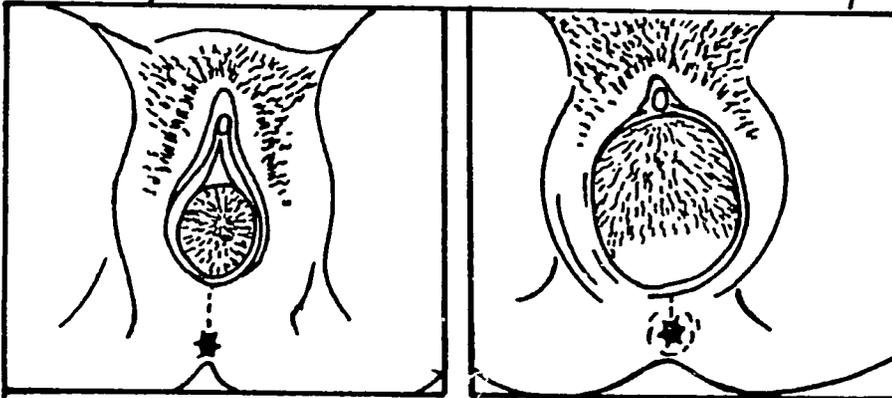
Debe hacer la limpieza de arriba hacia abajo.



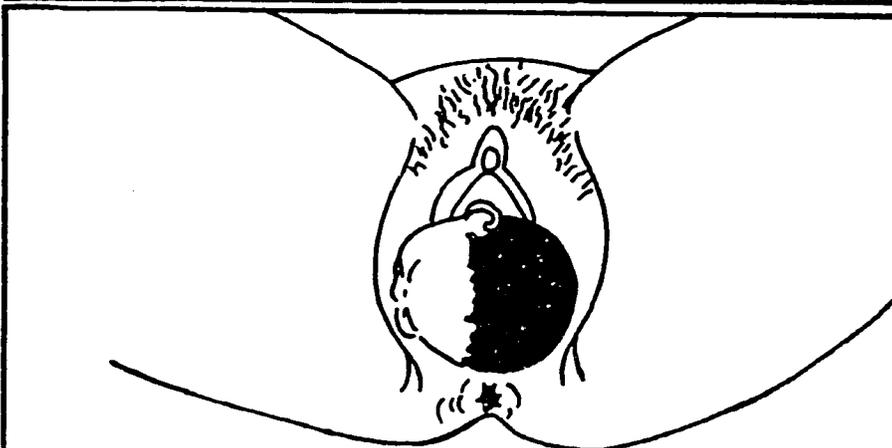
Las contracciones o dolores han hecho su trabajo, han ayudado a abrir el cuello uterino completamente (10 centímetros) el niño está listo para abandonar su nido y salir a conocer el mundo exterior.



46 Segundo Período (Trae al Niño) y lo que hace la Comadrona.



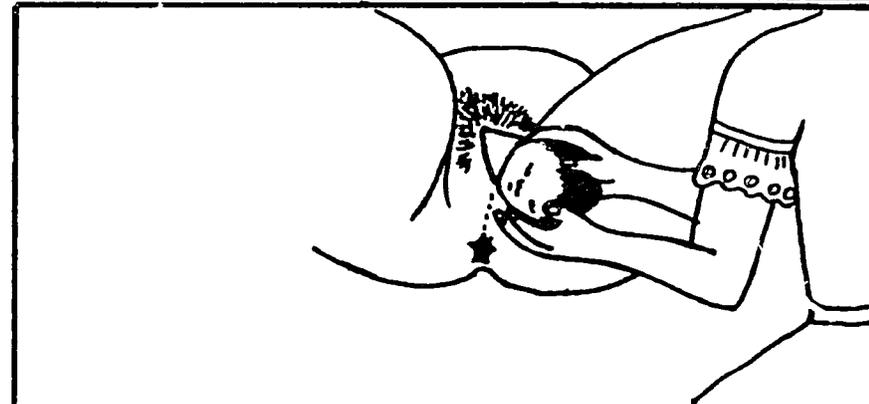
Con cada contracción o dolor se abulta la vagina y el periné, enrojece y brilla la orilla y luego aparece el pelo de la cabeza del niño, se abre el ano y se corona la cabeza del niño, esto se llama: Coronamiento. Si la cabeza ya está por salir y no se ha roto la fuente, hay que romperla con los dedos para que el niño pueda salir.



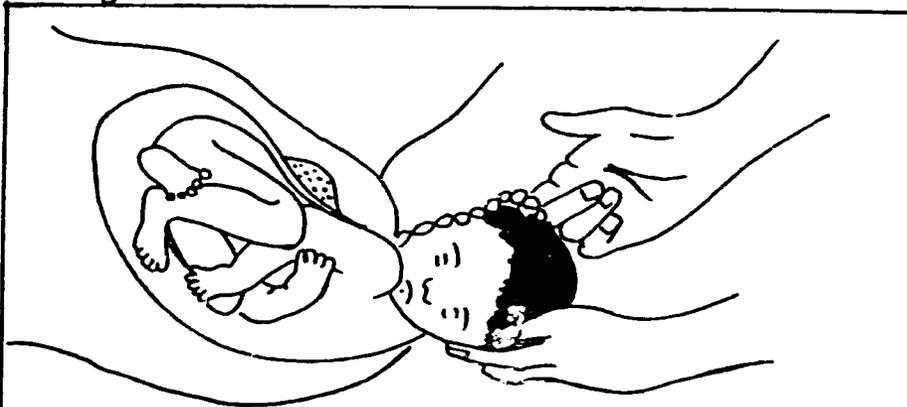
Se debe esperar a que voltee la cabeza del niño por sí solo. Recordar a la madre cuándo debe y cuándo no debe hacer fuerza. Debe seguir haciendo fuerza con los dolores y cuando no hay dolor descansar y respirar profundamente.



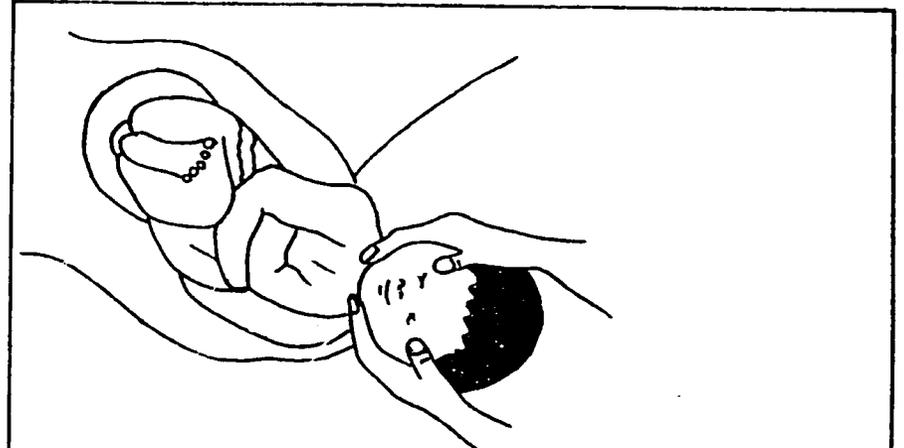
Al salir la cabeza ya no desaparece, sigue abultado el periné se apoya apretando con una mano, con trapo limpio, la parte baja del periné, para que no se rompa la piel; con la otra se detiene suavemente la salida brusca del niño. En este momento salió la cabecita boca abajo. Seguir apoyando el perineo, si salen heces, limpiar con otro trapito.



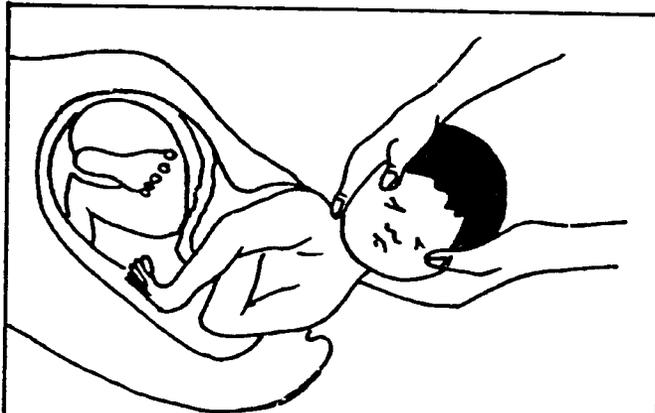
Al nacer la cabeza del niño debe sostenerla con las manos, para evitar que sangre, moco y popó puedan ensuciarlo y que lo aspire al empezar a respirar.



Si naciera con el cordón enrollado en el cuello, tratar de resbalarlo suavemente alrededor de la cabeza.
Hay que tratar con mucho cuidado. El cordón no hay que jalarlo ni cortarlo.



Al voltear la cabeza, tomarlo con las dos manos, jalando suavemente para abajo liberando el hombro de arriba.



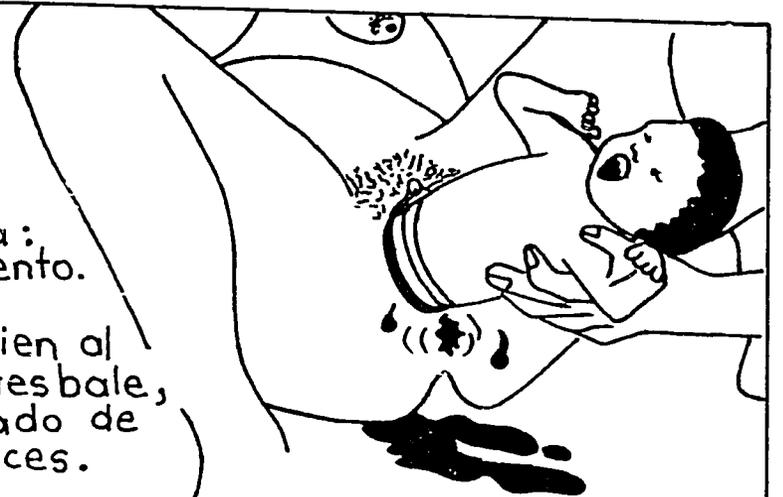
Levantar ahora la cabeza para liberar el hombro de abajo

En seguida sale completamente el niño. Esto se llama: Trauma del Nacimiento.

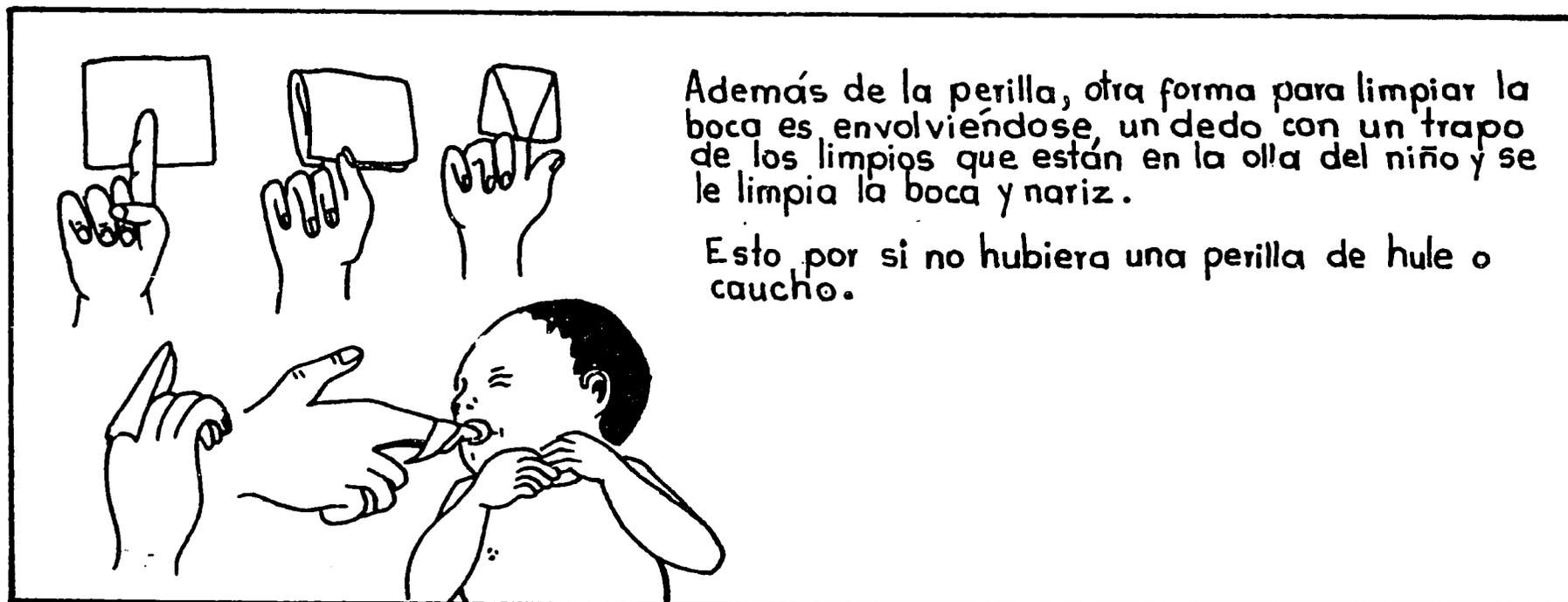
Hay que cogerlo bien al niño para que no resbale, ya que viene bañado de mucho sebo a veces.

Hay que estar muy atento al llanto inmediatamente que el niño nace porque esto nos indica que ha empezado a respirar, casi siempre lo hace sin problemas.

Aquí termina el segundo período del Parto.



Cuidados al Recien Nacido.



Cuidados al Recien Nacido



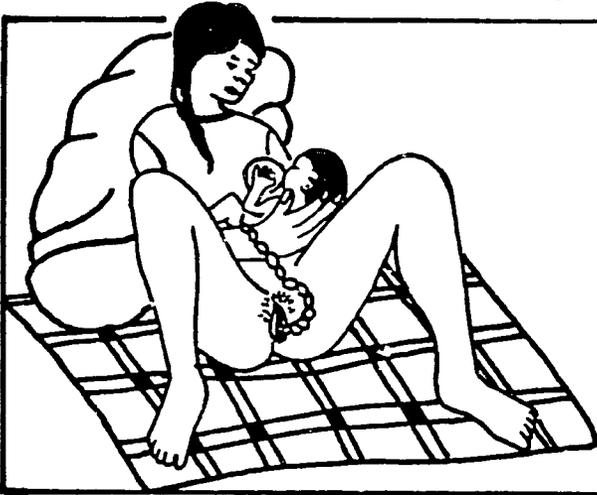
Atender la Respiración.

- Casi siempre el niño al nacer llora y respira bien. Ahora si esto no sucede hay que hacer lo siguiente:
 - Aspirar la flema rápido y cogiéndole los pies hacia arriba y al terminar de aspirar se le dá una palmada en la planta de los pies.
 - Poner al niño en posición de drenaje inclinado, colgado de los pies, teniendo siempre cuidado porque es muy resbaloso. Lo importante aquí es inclinarlo con los pies en alto, pero no más alto que el cuerpo de la madre.

- si no respira bien con lo anterior darle respiración artificial así:
 - tapando la nariz y boca del niño con la boca de la persona que atiende el parto, soplar las veces que sean necesarias; al ver que el niño respira bien dejar de soplar.
 - Al dar respiración artificial al niño hacerlo suave e intermitente.
 - Poner una gaza o trapo limpio sobre la boca del niño al darle respiración.



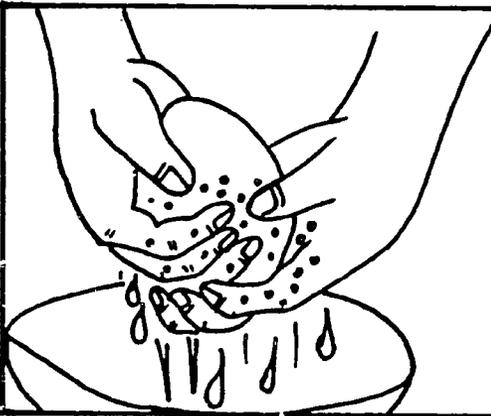
Cuidados al Recien Nacido.



Ponerle a Mamar:

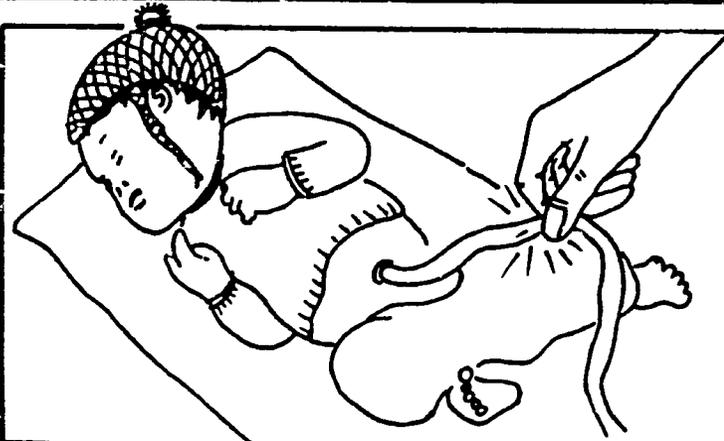
Poner a mamar al niño desde que nace para que ayude a que nazca la placenta más rápido y sentir que su madre lo quiere.

* Felicitar a la madre por su buen trabajo *



Lavarse las Manos

Antes de amarrar el cordón, lavarse las manos de nuevo para no infectar el cordón. El niño puede enfermarse y hasta morir de tétanos o el mal de los siete días, por no tener cuidado e higiene en nuestras manos y en lo que usamos, como la hoja de rasurar o tijeras que tienen que estar hervidas.

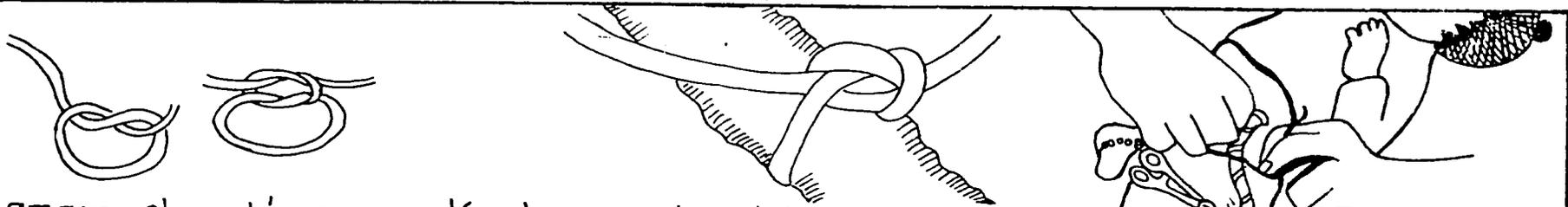


Amarrar el cordón umbilical

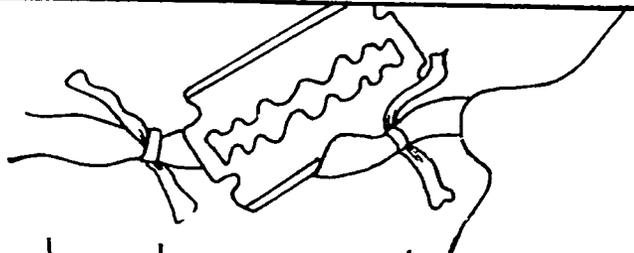
Cuando el cordón umbilical se pone blanco y deja de pulsar es que ya ha pasado toda la sangre de la placenta al niño, entonces ya se puede amarrar (ligar) y cortar, con las cintas esterilizadas (hervidas).

Tener cuidado de no jalar el cordón, ni tirar de él o poner tensión.

Tapar al niño con una sabanita para que no se enfríe.



amarrar el cordón a 3 centímetros arriba del ombligo, con un nudo doble cuadrado asegurándose de apretarlo bien, para que no se desate, se afloje y cause hemorragia (sale sangre). Se le hará una segunda ligadura o amarre a 3 centímetros de la primera. Revisar constantemente que el cordón no esté sangrando. Si sangra hacer otro amarre con otra ligadura o cinta.



Luego de esto con unas tijeras hervidas y de puntas redondas se procede a cortar el cordón, si no tenemos tijeras o no tenemos cómo esterelizarlos, es preferible usar una hoja de rasurar hervida que esté nuevo.



El último paso en el cuidado del cordón es cubrirlo con una gaza esteril, procurando no tocar la punta cortada para no contaminarlo. La gaza no se toca en el centro sino sólo en las orillas y se fija o se amarra con una cinta. Al bañar al niño no hay que mojar el cordón. La gaza puesta al cordón no se cambia, ésta cae con el cordón a los 8 días. Si hay hemorragia en el cordón hacer un nuevo amarre y poner otra gaza encima de primera.

Limpieza de los ojos: es necesario usar gotas de algún antibiótico para los ojos para prevenirle enfermedades, por cualquier microbio que pudiera haber estado en contacto con sus ojos al pasar por la vagina. En algunos lugares preparan gotas con limón y agua hervida en partes iguales y le hechan 2 gotas en cada ojo.

La limpieza del Cuerpo: la primera limpieza que se le hace al niño es para quitarle las manchas de sangre y lavarle sus ojos, se hace con agua tibia sin jabón, no quitarle la capa blanca de grasa, por que le protege y es alimento para su piel.



El Peso al Nacer

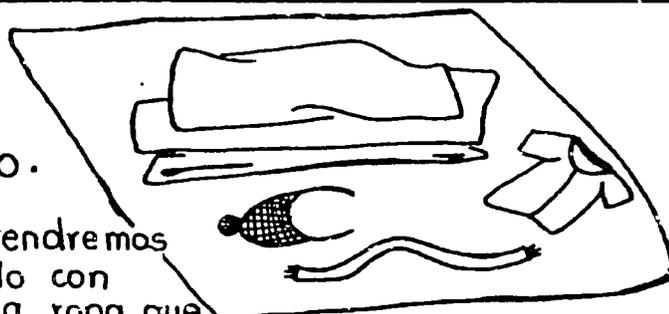
Tener listo la romana, es importante pesar al niño con poca ropa.

Si el niño pesa menos de seis y media libras es señal que necesita más atención en taparlo bien, en ver que no se ponga amarillo, que tenga buen calor y que mame bien. El peso del niño al nacer nos sirve para controlarle su crecimiento y desarrollo.



La Ropa del Recien Nacido.

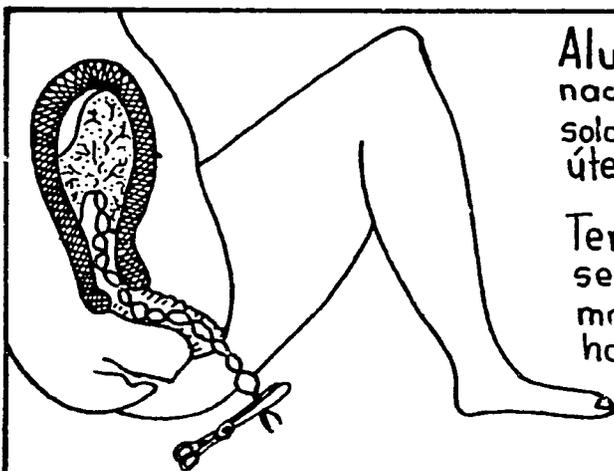
También tendremos preparado con tiempo la ropa que utilizará el niño. Hacerlos flojos, con costuras muy pequeñas para que no le lastime al niño, tiene que ser limpia. La necesidad en las comunidades de poner ropa vieja, se debe a la dificultad que se tiene de comprar nueva. No es necesario que sea nueva, lo necesario es que se le haga del tamaño adecuado y no ponerle bolsas y algunas veces mangas y que hayan sido lavados con suficiente agua y jabón, secados al sol, al aire y en alto.

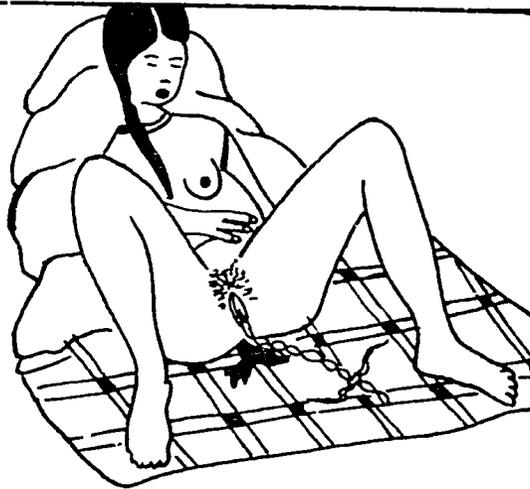


Tercer Período del Parto o sea el "Alumbramiento"

Alumbramiento: Este período comienza cuando el niño ha nacido, el cuello está borrado, la matriz abierta, ya salió el niño solo la placenta queda y empieza a separarse de la pared del útero.

Termina con el nacimiento de la placenta o compañera, también se le llama "alumbramiento"; este período tarda media hora mas o menos, si pasa mas de dos horas y no nace la placenta hay que llevarla al doctor o al hospital.

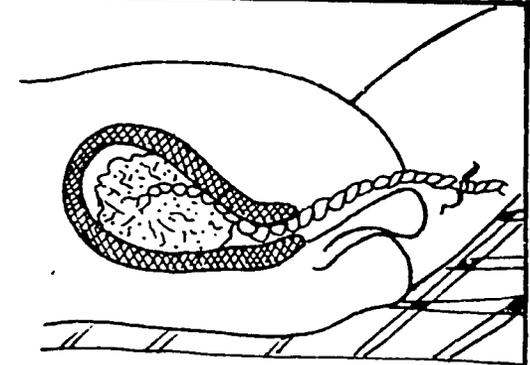




En este período se ve el "cordón", colgado por la vagina. Comienza de nuevo los dolores o contracciones, 5 o 10 minutos después del nacimiento del niño, hasta que salga la placenta.

- El cordón sale poco a poco.
- Sale mas sangre.
- Enseñarle a la madre a que sobe o se dé masajes en su abdomen, comenzando de abajo hacia arriba.
- El cordón es bien largo y no hay pena que regrese todo a la matriz.
- Si se jala el cordón se debe hacer con cuidado para no romperlo.
- Cuando no hay pinza se amarra la punta con una cinta.

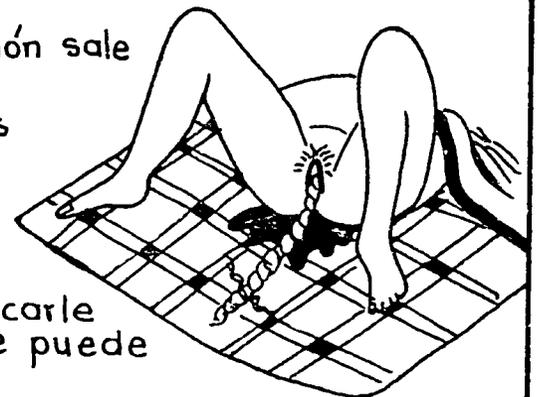
- Hacer fuerza con cada dolor o sea pujar hacia abajo, si no hay dolor, no hacer fuerza. No amarrar la cintura.
- Nunca jalar el cordón con fuerza, sino lentamente, porque puede arrancarle tiras a la placenta y causar hemorragias, cuando la madre puja se puede bajar el cordón suavemente, dándole 3 vueltas en círculo.

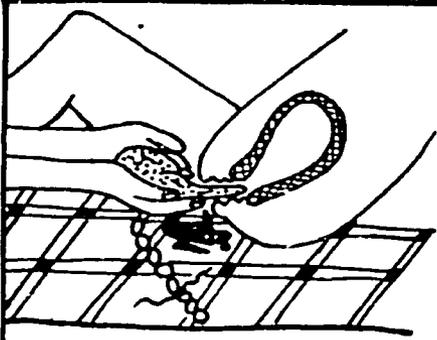


Empieza el desprendimiento de la placenta o compañera.

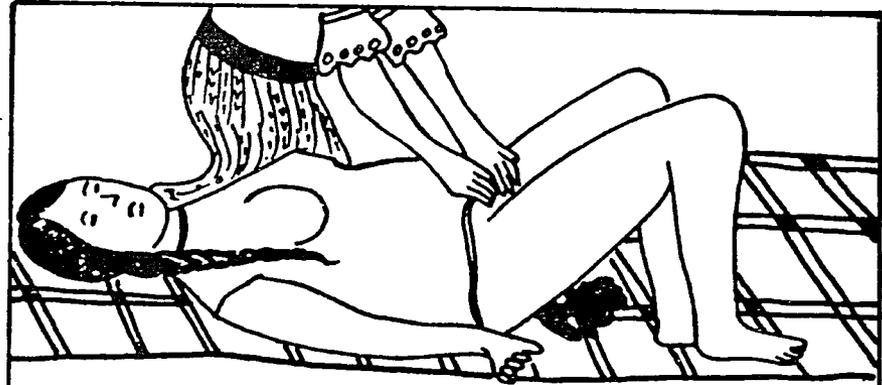
- En unas comunidades se espera hasta que salga la placenta.
- No hay pena de cortar el cordón antes de que salga la placenta, pero hay que amarrar bien la punta y hay que dejarlo lo mas largo posible pero jalarlo con cuidado.
- Asi se puede atender mejor al niño y se espera tranquilamente la salida de la placenta.

- Como vimos el cordón sale más.
- Sale más o menos media taza de sangre.

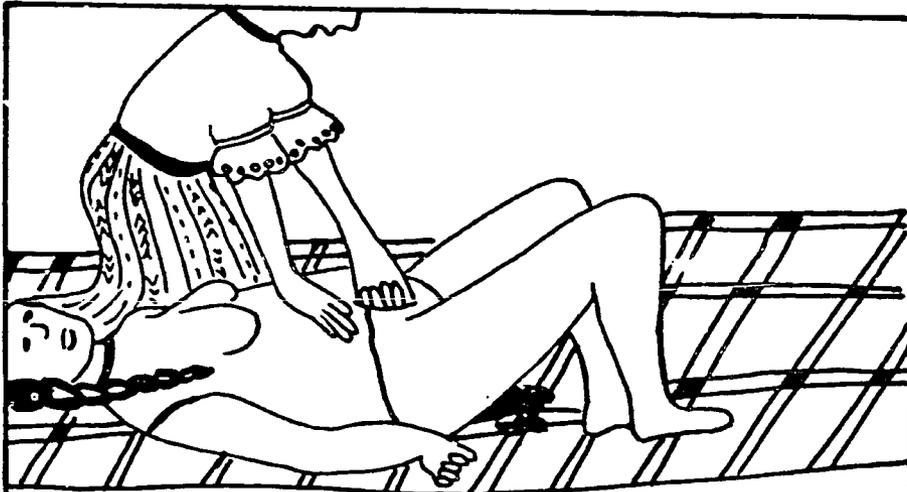




- La placenta aparece en la vagina, es parecido a hígado de res.
- La matriz se siente arriba del ombligo, como un cuerpo duro y redondo, se mueve sin resistencia de un lado a otro.



Si la placenta tarda en salir, o no hay contracciones, la comadrona, promotor o persona que atendió el parto puede sobar la matriz de la madre hacia arriba, hasta que esté lista para salir.



Nunca deberá empujar la matriz o hacer fuerza para abajo con las manos.



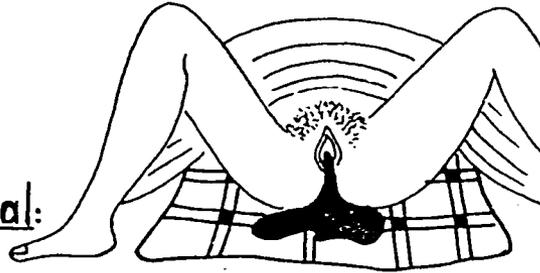
cara de la placenta que está pegada al útero.

cara de la placenta que la une con el niño.

Al salir la placenta, no olvidar revisarla para ver si salió entera (completa) o si falta algún pedazo, tener cuidado de que las telas que vienen atrás salgan todas y completas.

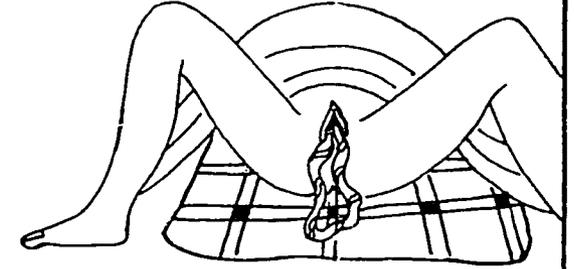
Peligros para la madre durante el parto que necesitan ayuda médica.

Hemorragia Vaginal:



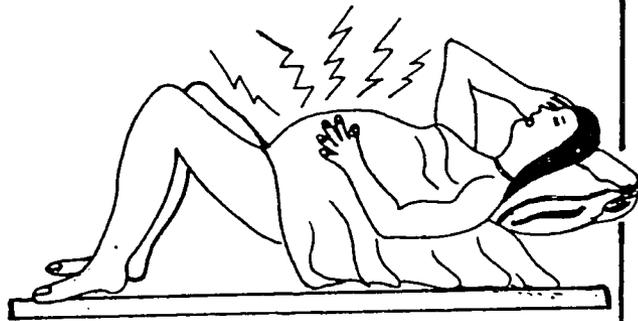
Llevarla en camilla, no se le darán ni inyecciones ni pastillas. Puede hacer daño a la madre y al niño.

Hemorragia vaginal, salida de mas de un litro de sangre fresca (no oscura) y el niño todavía no ha nacido. Darle abundantes líquidos, ponerla en posición inclinada, con las nalgas mas arriba que la cabeza, llevarla al hospital.

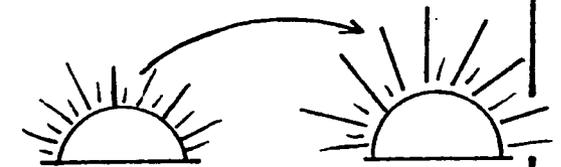


Salida del cordón primero: o sea que el niño no ha salido y el cordón ya se ve fuera de las partes de la madre.

No trate de meterlo adentro, acostar a la señora en camilla o sobre una tabla con las nalgas mas altas que la cabeza, llevarla al centro de salud u hospital.

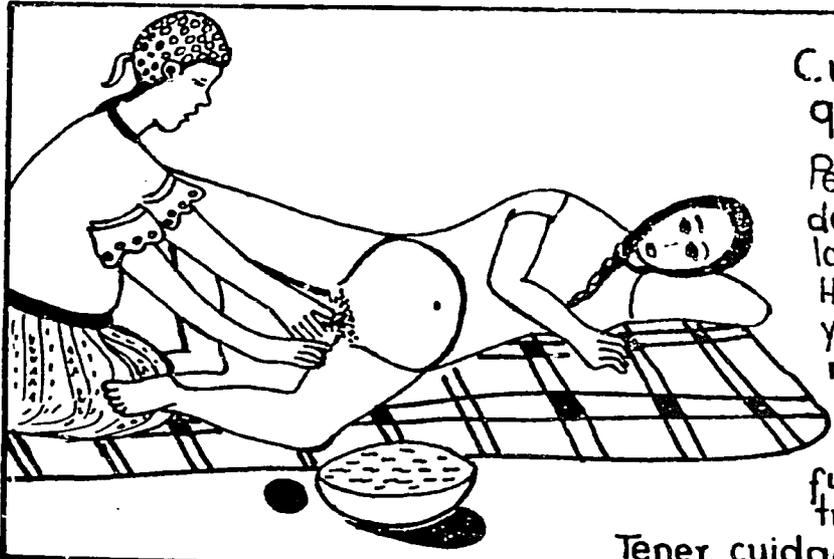


Dolores demasiados fuertes: que no se paran, el dolor continúa, al tocar la matriz se siente duro como piedra, no se pone aguado. No le dará ninguna medicina y la llevará lo mas pronto posible al hospital o Centro de salud.



Los dolores tardan mucho tiempo, mas de un día y una noche con dolores muy fuertes y eguidos y no da a luz. Llevar al hospital o Centro de Salud, no le dará ninguna medicina, puede dañar al niño o a la madre. No ponerle ninguna inyección de parto.

Cuidados a la Madre Después del Parto (Puerperio)

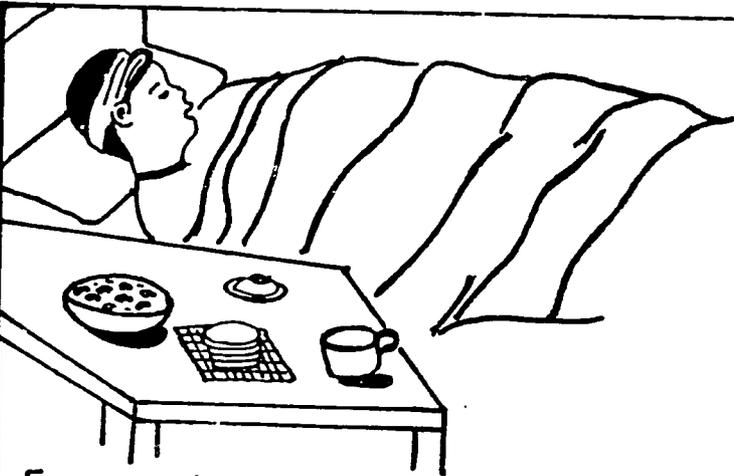


Cuidados Mediatos por Parte de la Persona que atendió el parto.

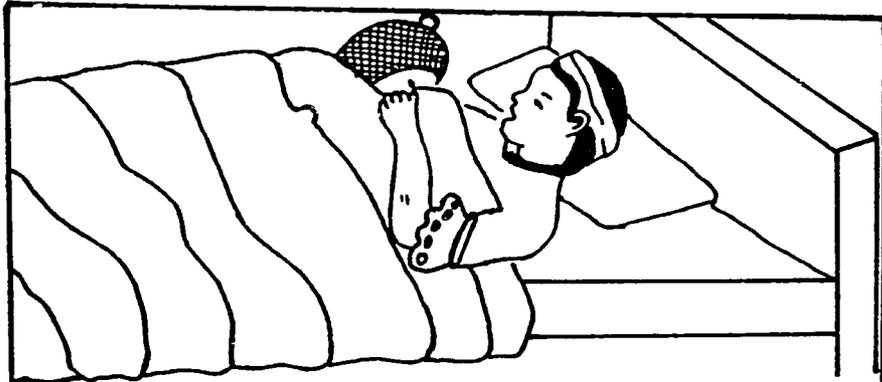
Permanecer en la casa por lo menos una hora, después del alumbramiento de la placenta para lo siguiente:

Hacerse cargo de la limpieza de la madre con agua y jabón (caliente-tibia), aprovechando para ver si la madre no sufrió algún desgarro (rasgadura) del cuello del útero o de la vagina, si estuviera sangrando, hacer presión o sea fuerza, con un trapo hervido, si fuera mucho, puede meter tiras de tela hervidas o trapos para ayudar a controlar la hemorragia.

Tener cuidado de no dejarlos adentro.



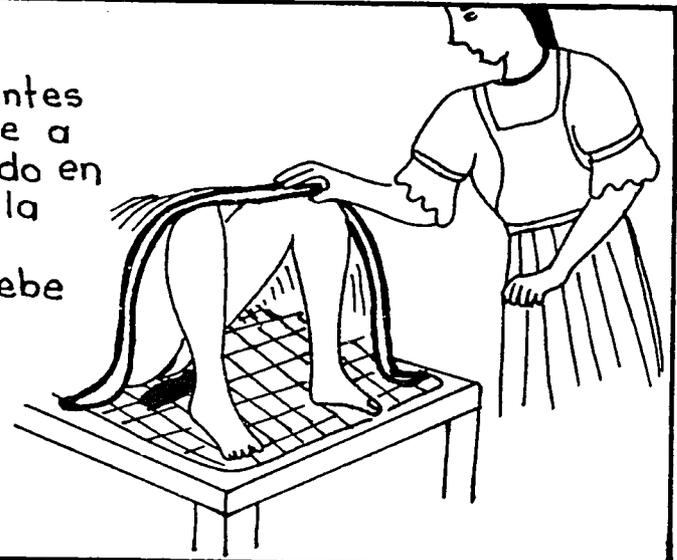
Es importante darle de comer, la madre ha trabajado mucho y duro, darle muchos líquidos y comida para que reponga fuerzas; puede comer de todo, menos tomar alcohol o sea aguardiente.



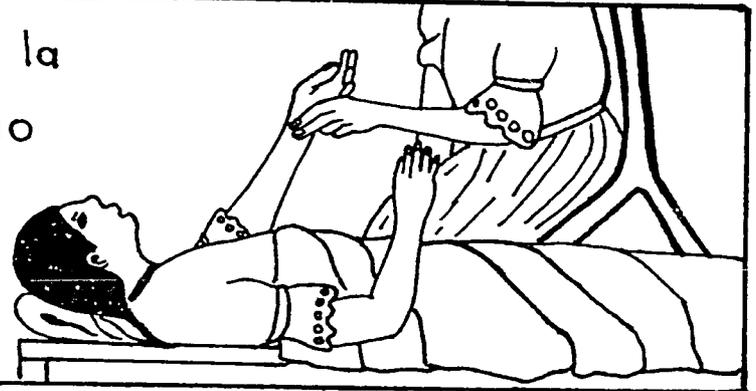
También es bueno tener el cuidado de acomodar a la madre, protegerla del frío, ya que muchas veces les da escalofríos y temblor de cuerpo después del parto, por mucho trabajo; cubrirla con suficientes ponchos.

Cuidados a la Madre Después del Parto (Puerperio)

Es muy importante que la persona que atendió el parto, antes de retirarse y como un cuidado especial: Revise y observe a cada rato el fondo de la matriz, para ver si se ha contraído en buena forma o sea para ver si está firme, puede sobar la matriz si se pone suave y aprovecha para observar la hemorragia, no perder mas de una taza de sangre y debe ser oscura, no fresca. Además ve si la madre ha orinado.

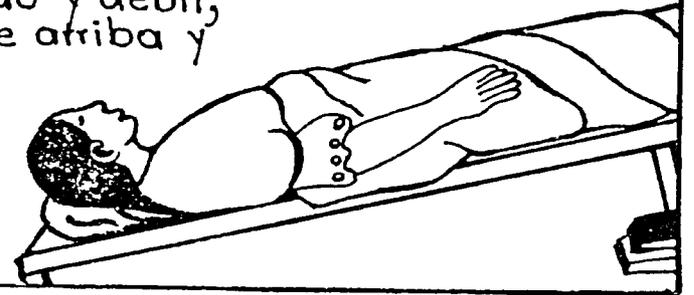


Controlar la temperatura, el pulso y la respiración de la madre para ver si está normal su estado. Antes de retirarse vigilará la hemorragia, reconocerá el fondo de la matriz, y lo aprieta para expulsar coágulos de sangre. El fondo como vimos antes debe quedar firme, sin que sangre mucho, si hubiera mucha hemorragia vigilar por shock o choque, esto se puede dar si la pérdida de sangre es mucha y no puede controlarse.

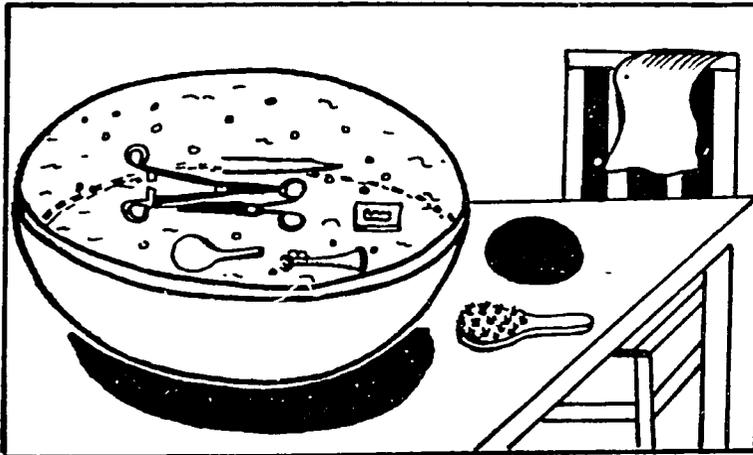


Las señales de choque son: palidez intensa, pulso rápido y débil, piel fría, perlas de sudor que se puede ver en el labio de arriba y en la frente, baja la presión arterial, hay indiferencia, desesperación.

Que hacer: mantener la temperatura normal. Hay que tratar de detener la hemorragia, subirle los pies y acostarla sobre una tabla, hasta que la cabeza quede medio metro por abajo de los pies.



Cuidados a la Madre Después del Parto o Puerperio



La comadrona, promotor o persona que atendió el parto, limpia sus instrumentos y todo lo que utilizó durante el parto, guarda en su maletín lo que le servirá para la próxima vez y tira lo sucio que tiene en la bolsa de nylon.

Trata de que la casa quede ordenado y limpio para ayudar al ambiente de la madre.



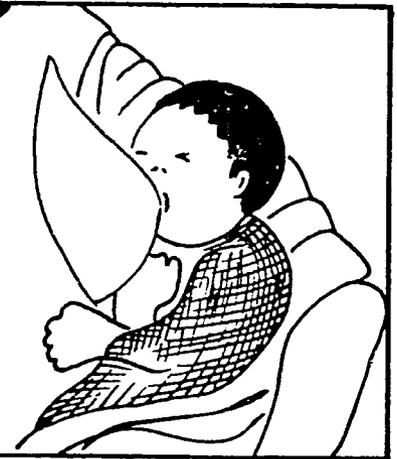
Es muy importante que la persona que atendió el parto orienta a la familia de la parturienta sobre la atención de la madre y del niño, así como de la importancia del control Post-Parto en el hospital, centro de salud o el médico.



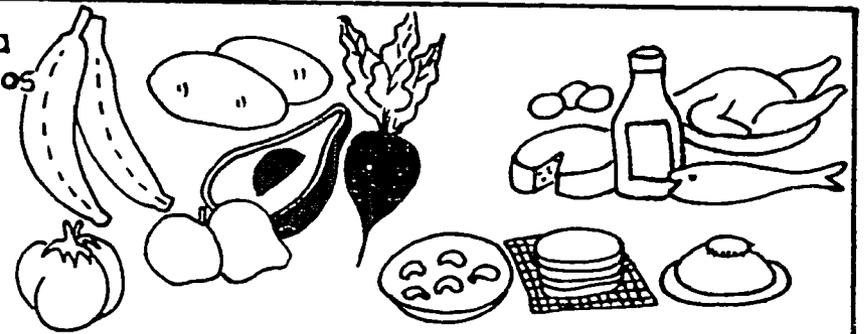
También que dé confianza y seguridad a la madre, le de apoyo con alegría para que la madre se sienta bien y serena, además "orgullosa de su trabajo"

Cuidados a la Madre Después del Parto o Puerperio.

En el post-parto o sea el puerperio, la madre tendrá que dar de mamar a su hijo, para esto debe tener cuidado con sus pechos, "la primera leche" es rara amarillenta y muy buena para el niño; baja a los 2 o 3 días, si el niño llora de hambre, se le puede dar agua hervida y azucarada hasta que baje la leche. Si la madre se tarda mucho tiempo en empezar a dar de mamar, los pechos se ponen duros hay que hacerse lienzos de agua caliente y seguir dando de mamar si no hay fiebre.



Es importante que la madre coma de todo o sea una dieta balanceada, alimentos de los 3 grupos que conocemos, además debe tomar bastantes líquidos, atoles, sopas etc. esto es para tener bastante leche, un té de anís o la alucema.



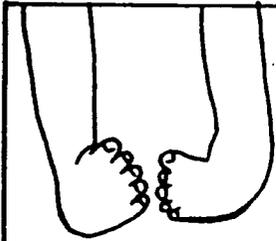
La limpieza de los pechos es muy importante: enseñar a las madres que han dado a luz que para evitar enfermedades en el niño y en sus pechos es necesario lavarlos con agua por lo menos una vez al día al bañarse y si no se baña hacerlo aparte. Si le sale mucha leche, colocarse telas y cambiarse las veces que sea necesario, no dejar que se le ponga dura la ropa por la leche.

También dará orientación a la madre sobre un flujo de sangre viejo que tendrá como regla de 10 a 14 días, luego un flujo de moco por 7 días mas o menos. Esto es normal.

Si hubiera mal olor o fiebre avisar al médico o llevarla al hospital o Centro de salud.

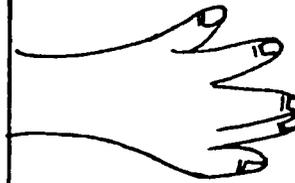


Enfermedades Congénitas o Defectos en el Recien Nacido



Pies Torcidos

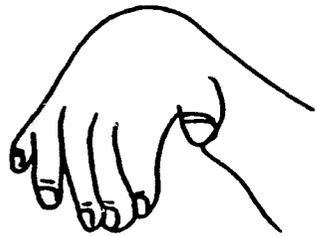
Se le llama pié equino o zambo equino. Hay que revisar si un pié o los dos estan torcidos para adentro o para afuera. Hay que llevarlo al hospital en la primera semana para que el doctor le ponga yeso en la pierna torcida y lo cambia cada 2 semanas hasta que esté recto, es mas fácil cuando está suave, un niño mas grande necesita muchas operaciones para poderlo corregir.



Dedos Juntos o Pegados

Se llama también Sindactilia: revisar sus manos y piés si tienen solamente 2, 3 o 4 dedos, porque unos están juntos, llevarlo al hospital, para ver si es posible que lo operen cuando está mas grande.

"Nunca debe probar cortar los dedos con ningún objeto como por ejemplo: una hoja de rasurar?"



Polidactilia

Revisar si las manos o piés tienen 6 dedos, revisar si éste tiene hueso o solo es carne

si el dedo demás es de pura carne puede hacer un nudo cuadrado y apretado en la base del dedo con un hilo fuerte que fué hervido en agua 20 minutos, para cortarlo.

Si el dedo de mas tiene hueso hay que llevarlo al doctor.



Revisar su espalda, ver si tiene bolsa o algo extraño; tocar la mollera para ver si no está muy partida, más de 2 centímetros, se llama Espina Bífida o Mielomeningocele, proteja la bola con gaza o trapo limpio, con cuidado de no lastimarlo, nunca se le meterá nada para ayudarlo, hay que llevarlo al hospital.

Enfermedades Congénitas o Defectos en el Recién Nacido.



Labio Partido =
Labio Leporino

Revisar la boca metiendo el dedo pequeño y tocando el cielo de la boca para ver si no está muy partido el paladar. Si también tiene partido el paladar o cielo de la boca se llama Paladar Hendido. Si no puede mamar, la madre se saca la leche y le da con cucharaditas o gotera, se le lleva al hospital para operación si es labio leporino a los 6 meses, si es paladar hendido al año y medio.



También es importante ver si el niño hace popó, darle de mamar, revisar el ano, se le puede tomar temperatura por allí para ver si no está tapado, si está cerrado, llevarlo al hospital.

Problemas para que la Madre sea Atendida en el Hospital. se puede dar durante o después del Parto.

Madre con mucha hemorragia:

Si es porque no sale toda la placenta, darle bastantes líquidos mientras se lleva al hospital, si es por rasgadura del cuello de la matriz o de la vagina después del parto, deberá hacerse presión con un trapo hervido sobre la rasgadura, si es porque no sale la placenta, llevarla a donde el médico y darle bastantes líquidos.



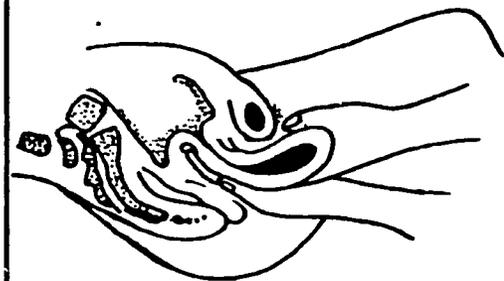
Problemas para que la madre sea Atendida en el Hospital. ^{Se pueden dar durante y después del Parto.}



Madre con calentura, frío y dolor de Estómago (matriz).

Puede ser por infección del post-parto, puede haber salida de moco secreción como de pus por las partes de la mujer, con mal olor, hay fríos y dolor de vientre y cabeza, se llama fiebre puerperal viene por mala higiene.

Llevarla al hospital para que le den tratamiento. Se ve a los 3 o más días después del parto.



Salida de la Matriz

Fuera de la vagina: puede suceder durante el alumbramiento o sea cuando sale la placenta, porque la persona que atiende el parto jala con fuerza el cordón y la placenta todavía no ha desprendido, entonces puede jalar la matriz hacia afuera y causar la muerte de la madre en 15 minutos.

La persona que le atiende deberá lavarse rápidamente y bien las manos, empujar la matriz hacia adentro otra vez, despacio pero con presión continua, esta es la única vez que la persona que atiende el parto puede meter la mano dentro de la vagina de la madre.

Acostarla con las nalgas mas altas que la cabeza y llevarla al Hospital.

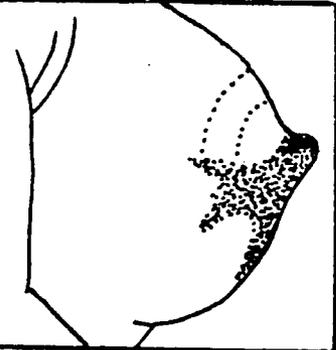
La Madre No Orina: puede ser porque no ha tomado líquidos, además los ha perdido sudando y trabajando durante el parto. Puede ser también que golpee la salida de la orina durante el parto.

Que hacer:

Darle de tomar muchos líquidos, revisar la vejiga si está grande encima de la matriz y dolorosa, sentarla y ayudarla a que camine, ponerle lienzos calientes encima del abdomen (estómago), si no orina sentarla en una tina (palangana grande) con agua caliente por 10 minutos o 15, también es bueno dejar correr agua como si fuera un chorro para que la madre tenga el deseo de orinar, si no se logra que orine, llevarla al hospital.



Mastitis o Infección del Pecho: se hincha, duele, está rojo y caliente (Nacido del pecho) se le recomienda lienzos al pecho afectado con agua caliente, que el niño siga mamando, sacar la leche (ordeñarlos) debe seguir comiendo, tomar muchos líquidos, descansar. Debe ir al médico o al hospital para que la examine y vea si es necesario que le dé un antibiótico.



Tromboflebitis o Hinchazón de la pierna: sucede a los 10 días después del parto, hay calentura, se hincha una pierna, hay dolor, se ve blanca, muy pálida, puede haber escalofríos.

Recomendarle a la Madre: reposo absoluto, no levantarse de la cama, no puede levantarse o comer ni hacer sus necesidades, si fuera demasiado el dolor darle aspirina, lo mejor es llevarla al hospital, para que sea el médico quien le dé el tratamiento. No dejar que pase más de 4 o 5 días.

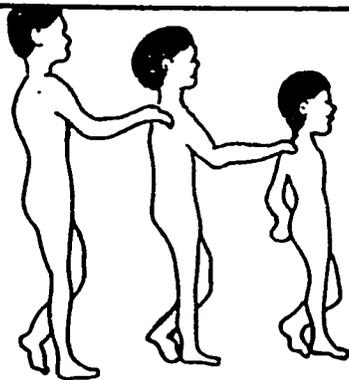


Crecimiento y Desarrollo del Niño

Para que el niño pueda crecer y desarrollar bien, es muy importante los cuidados de los padres y la familia en general respecto a la alimentación el cariño y el juego.



Algo muy importante para recordar a todos es que no se trata de buscar la competencia, la preocupación, ni el orgullo de los padres; tomando en cuenta que no todos los niños son iguales, algunos se adelantan, otros se atrasan en realizar lo que la mayoría hace en cierta edad; lo que si se busca es su orientación y responsabilidad para saber que cosas son normales, que no y cuando consultar a un trabajador de salud.



Para que este tema se entienda mejor, vamos a seguir estos cuatro pasos en cada edad.

1. Crecimiento y desarrollo:

El crecimiento son los cambios que el cuerpo va realizando, para esto es muy importante la alimentación.

El desarrollo son las distintas actividades que el niño logra hacer a medida que va creciendo, para esto es muy importante el cariño y el entretenimiento de los adultos al niño.

2. Actividades :

Aquí se pone una lista de los trabajos recomendables para entretener al niño según su edad; cada persona puede tener otras ideas y realizarlas; en estos casos hay que observar si el niño lo usa menos, igual o más que las de la lista.

Todas estas actividades se llaman: Estímulos o Educación Inicial.



3. Cuidados :

Aquí se escriben ideas que dicen cómo es el niño y los cuidados que los adultos deben tomar en cuenta para atenderlos lo mejor posible.



4. Juguetes y Materiales:

Son ideas y recomendaciones de lo que se puede usar en las distintas edades del niño; cada persona puede tener ideas sobre esto y usarlo; solo tomar en cuenta que no cause algún daño al niño y si estas nuevas ideas son menos, igual o más aceptadas y usadas que las escritas en la lista.



La Mejor Herencia para un Hijo, es el Tiempo que los Padres le Dedicar cada día ...

El Niño Desde el Nacimiento. Hasta los 3 Meses.



Crecimiento y Desarrollo

Duerme la mayor parte del tiempo. Estando boca abajo aprende a levantar la cabeza y a mantenerla así por momentos. Mira todo lo que le rodea. Sigue con los ojos las cosas que se mueven. Mira las caras y sonríe. Reconoce a su mamá, a su papá, si lo ve todos los días.

Mueve los brazos y las piernas, cuando en ellos siente dolor, comezón o frío. Apacha las cosas que le dan, hace pequeños sonidos con la boca. Es suficiente alimentarlo con la leche materna.



Actividades

- Mantener al niño cerca de la madre. Hacerle cariño.
- Dejarlo que se mueva, poniéndole pañales un poco flojos. Cantarle y hablarle.

Ayudarle a que mire lo que pasa a su alrededor. Cuando está despierto llevarlo al lugar donde está reunida la familia. Colgar, cerca de la cama cosas llamativas que él pueda seguir con los ojos.



Cuidados

Recordar que el niño recién nacido puede ver y reconocer lo que ve. Se comunica a su manera con las personas y cosas que están cerca de él, por eso cuando la mamá le grita, le hace cariño o juega con él, el niño contesta asustándose, llorando, riendo, pone atención. No es necesario darle leche de bote ni usar pacha. Lavarse el pecho la madre, una vez al día. Llevarlo al control para su peso y salud.



Juquetes y Materiales

- Cosas limpias, de madera, plástico, para que los toque.
- Pedazos de tela y papel, de colores fuertes, colgados cerca de su vista.
- Borlas de lana, plantas, flores, la ropa, cuadros, círculos, sonajas, anillos para que vea distintos colores, texturas y formas.
- Cajitas de diferente material y diferente sonido.

El Niño de 3 a 6 Meses

Crecimiento y Desarrollo

- Deteniéndole con algo puede estar sentado un rato.
- Empieza a agarrar las cosas que tiene cerca.
- Alarga la mano hacia las cosas que le ofrecen.
- Se lleva las cosas a la boca.
- Busca el juguete perdido.
- Trata de mirar personas y cosas distantes.
- Se ríe a carcajadas, da gritos de alegría cuando juega con los adultos.



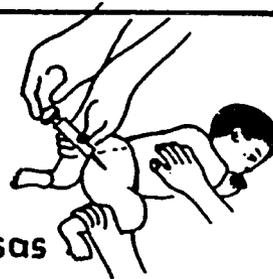
Actividades

- Todos los anteriores.
- Mantener al niño sentado, en las rodillas, durante largo rato.
- Ponerle cerca cosas que pueda agarrar y llevarse a la boca sin peligro de tragarlos o lastimarse.
- Con ayuda de almohadas ponerle entre acostado y sentado.
- Reír, cantar y jugar con el niño.
- Enseñarle cosas, cerca, lejos, izquierda, derecha abajo. Atraer su atención mediante sonidos.
- Que saque y meta juguetes de una caja, bolsa, recipiente, etc.



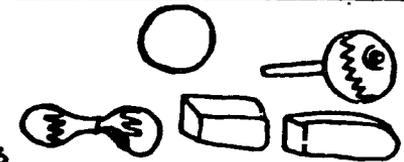
Cuidados

- Al agarrar las cosas, no usa el dedito gordo.
- Se mete a la boca las cosas que tiene cerca.
- En este tiempo, la boca le sirve mucho para conocer las cosas.
- Lavarle los juguetes diariamente.
- Vacunarlo; a los 4 meses comenzar a darle alimentos; que siga mamando.
- No darle objetos que se destiñen o se deshacen como papel.

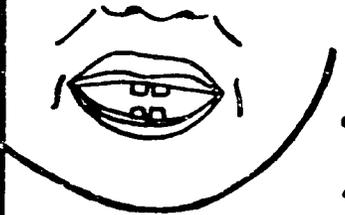


Juguetes y Materiales

- Todos los anteriores hasta que el niño los deje.
- Pequeñas cosas que no lo lastimen ni pueda tragar.
- Pedazos de madera.
- Chinchines.
- Cajas de cartón.



El Niño de 6 a 9 Meses.



Crecimiento y Desarrollo

- Puede estar sentado por ratos.
- Da vueltas para ponerse boca arriba o boca abajo.
- Puede moverse para acercarse a una persona o cosa.
- Si se le agarra, puede estar parado.
- Agarra una cosa con cada mano.
- Juega tirando cosas.
- Dice el mismo sonido varias veces, por ejemplo: "ma, ma, ma".
- Conoce a las personas de su familia y puede tener miedo a otras personas.
- Comienza a jugar con otra persona (golpear las manos, jugar a escondidas).
- Pasa una cosa de una mano a otra.
- Gatea.
- Le salen los primeros dientes.
- No es suficiente mantenerlo con leche materna.



Actividades

- Todos los anteriores.
- Poner al niño sobre el petate o poncho en un lugar seguro.

- Ayudarlo para que pueda sentarse y resbalarse.
- Tenerlo cerca para que tome parte en la vida familiar. Jugar con él, devolviéndole las cosas que tira al suelo. Hablarle bien no como chiquito. Al bañarlo, cambiarle de ropa y darle de comer, hacerlo con cariño, alegría, como jugando.
- colocarlo frente al espejo, sacar y meter juguetes de cajas. Poner y quitar juguetes sobre camas y mesas. Ponerle juguetes debajo de alguna tela para que él lo descubra. Vejigas infladas con dibujos que los jale y siga los movimientos.



Cuidados

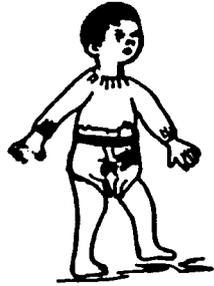
- Hay que cuidar al niño para que no se caiga.
- No dejar que el niño se meta en la boca cosas que lo puedan ahogar, envenenar o lastimar.
- Darle de comer 3 veces al día.



Juguetes y Materiales

- Todos los anteriores, hasta que el niño los deje.
- Pelotas de trapo o plástico.
- Animales de trapo. Pedazos de madera.
- Vejigas, espejo, telas, camas y mesas de la casa.

El Niño de 9 a 12 Meses.



Crecimiento y Desarrollo

- Puede pararse sin que lo ayuden.
- Si lo agarran de las dos manitas puede caminar
- Después caminará agarrado sólo de una mano o apoyándose en un mueble.
- Repite con la boca o golpeando una cosa con otro, los ruidos que oye.
- Se mueve cuando oye música.
- Entiende y hace caso cuando se le dice que haga o no haga algo.
- Se interesa por conocer todo lo que toca, oye o mira.



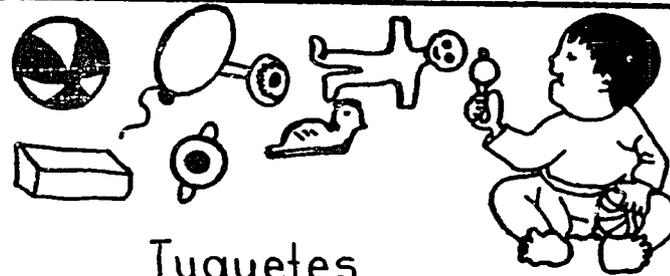
Actividades

- Dejarlo gatear, procurar que gatee mientras se le valancee para que aprenda a guardar equilibrio.
- Ayudarlo a caminar agarrándolo de las dos manos.
- Mostrarle cosas nuevas
- Ayudarlo a conocer la casa.
- Enseñarle palabras fáciles.
- Que jale juguetes, objetos detrás de una pantalla como: nailón, material de radiografía ya lavado para que él logre localizarlo.



Cuidados

- Además de los cuidados de la edad anterior (de 6 a 9 meses), no deben dejarse cosas peligrosas cerca del niño.
- Tener cuidado que el niño camine sin peligro en la casa.
- Vacunarlo contra sarampeón.



Juguetes

- Todos los anteriores, más.
- Pelota de trapo o plástico.
- Pedazos de madera. Juguetes de trapo.
- Otras cosas que no lo lastimen. Colocarle cintas o varios juguetes, para que los jale.

El Niño de 12 a 18 Meses.



Crecimiento y Desarrollo

- Camina y pasea sólo por la casa.
- Pone un pedazo de madera sobre otro, hasta llegar a tres.
- Llena de agua un trasto.
- Puede decir de cinco a diez palabras. Se pone celoso, se molesta y quiere mandar cuando juega con sus hermanos mayores.



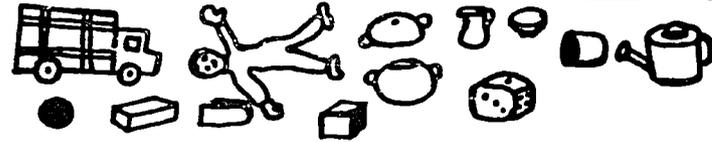
Actividades

- Enseñarle a llenar y vaciar trastos con agua o arena.
- Platicarle bastante, despacio y con palabras bien dichas.
- Contarle pequeños cuentos.
- Enseñarle que quieren decir las palabras atrás, adelante, antes, después, aquí, allá, arriba, abajo, etc.
- Que introduzca bolas, botones en recipientes grandes, medianas, agujeros pequeños. Que encaje objetos pequeños en otros de mayor tamaño.
- Que haga o deshaga: camino, montaña etc. con arena o tierra. Que coloque objetos sobre otros, que construya.



Cuidados

- Tener en cuenta que el niño está aprendiendo a vivir con otras personas, es natural que se enoje fácilmente.
- Cuidar al niño para que no se caiga o se golpee.
- Ponerle los refuerzos de vacunas.



Juguetes y Materiales

- Pedazos de madera o cajas de cartón
- Trastos con piedra o arena.
- Juguetes con ruedas para jalar o empujar
- Pelotas. Muñecas de trapo.
- Fotos o dibujos de almanaques, especialmente de miembros de la familia o del ambiente del niño, plantas, animales, casas, vestuario y figuras cortadas.

El Niño de 18 Meses a 2 Años

Crecimiento y Desarrollo

- Con la ayuda de una persona mayor, sube y baja gradas.
- Pone, uno sobre otro, cuatro pedazos de madera.
- Aprende nuevas palabras.
- Come sólo.
- Empieza a avisar cuando quiere hacer sus necesidades.
- Le gusta hacer lo que hacen las personas mayores.
- Le gusta jugar con otros niños, pero a su modo y usando sus propios juguetes



Actividades

- Ayudarlo a subir y bajar gradas. Felicitarlo cuando aprende algo nuevo.
- Pedirle que señale la boca, la nariz, las orejas y dejarlo comer sólo, aunque se ensucie.
- Dejarlo que juegue con agua y arena.
- Contestar, con palabras fáciles sus preguntas. Mostrarle y decirle el nombre de las cosas.
- Tapar y destapar envases.
- Aprovechar figuras y fotos para mostrarle, enhebrar objetos con agujeros grandes.
- Inicio al garabato, que haga rayas en el suelo con sus juguetes. Que haga rodar círculos.



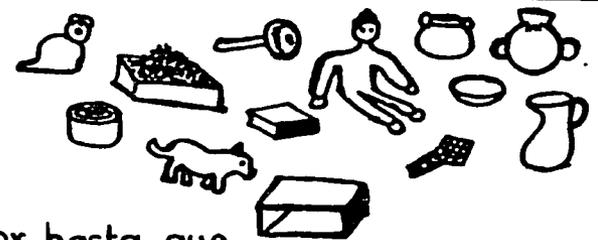
Cuidados

- Tener cuidado que no se lastime.

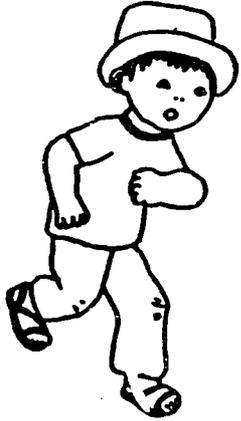


Juguetes y Materiales.

- Todo lo anterior hasta que el niño lo abandone.
- Agua y arena.
- Papeles . Muñecos.
- Pedazos de madera. Envases con tapadera, objetos con agujeros grandes, círculos.
- Album, figuras, carbón o tiza.

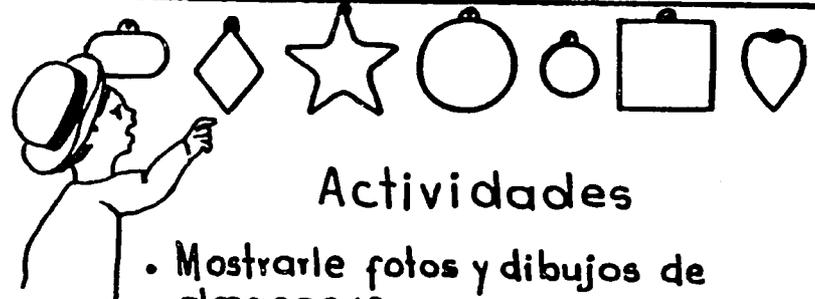


El Niño de 2 a 3 Años.



Crecimiento y Desarrollo

- Puede brincar en un pié.
- Hace preguntas y aprende nuevas palabras.
- Cuando habla usa el "yo".
- Entiende casi todo lo que le dicen.
- Puede hacer una ruedita en un papel o en el suelo.
- Le gusta jugar con otros niños.
- Comienza a entender que afuera de su casa también hay personas y cosas.



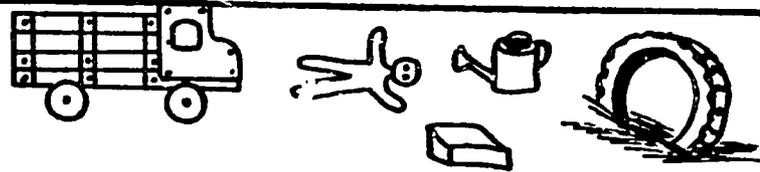
Actividades

- Mostrarle fotos y dibujos de almanaque.
- Ayudarlo a conocer las cosas que usa.
- Enseñarle a conocer las cosas que usa.
- Enseñarle a decir el nombre de las cosas.
- Enseñarle a conocer las partes de su cuerpo.
- Enseñarle a comparar tamaños (grande, pequeños, largo, corto).
- Ayudarlo a que entienda que quiere decir parado, sentado, acostado. Que forme figuras cortadas en 2, 3, 4 partes.



Cuidados.

- Algunas veces, dejarle hacer lo que quiere.
- Procurar que juegue con otros niños.



Juguetes y Materiales

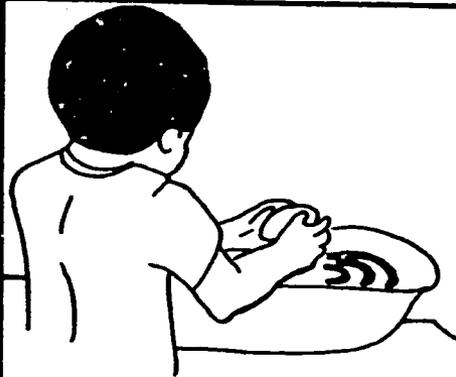
- Continuar con los juguetes anteriores: papel, lápices, yeso o carbón.
- Enseñarle a hacer juguetes, rompe cabezas sencillas.

El Niño de 3 a 4 Años.



Crecimiento y Desarrollo

- Pasea sólo. Se viste y desviste sólo.
- Durante la noche ya no se orina en la cama.
- Cuando dibuja personas, ya les pone varias partes del cuerpo.
- Conoce dos o tres colores.
- Dice cómo se llama y cuántos años tiene.
- Pregunta mucho.
- Quiere saber cómo nacen los niños.
- Entiende qué es alto, bajo, atrás y adelante.
- Le gusta que le cuenten cuentos.
- Pide que le vuelvan a contar el que más le gusta.
- Es cariñoso con sus hermanos.
- Puede hacer algunos trabajos fáciles.



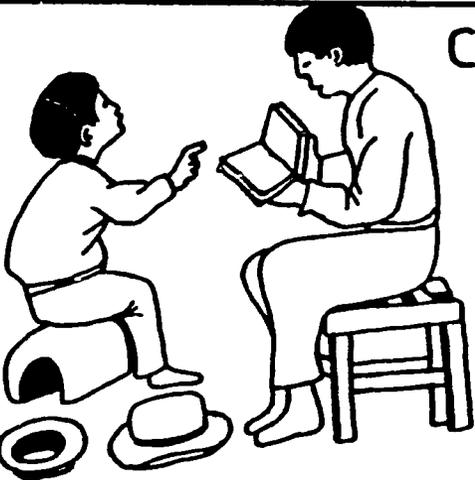
Actividades

- Ayudarle a correr y a brincar.
- Enseñarle nuevas palabras y ayudarle para que los diga bien.
- Darle trabajos que pueda hacer y que le guste.
- Pedirle que se lave y que se vista.
- Darle las gracias por los trabajos que haga.
- Enseñarle nuevas formas de jugar.



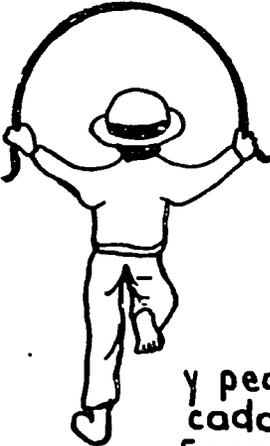
Juguetes y Materiales.

- Todo lo anterior hasta que el niño los abandone.
- Lápices, papel, yeso o carbón.
- Juguetes que él haga.



Crecimiento y Desarrollo.

- Brinca y se columpia.
- Puede subir y bajar gradas sin ayuda de otras personas.
- Cuando dibuja personas les pone casi todas las partes.
- Se le entiende bien lo que habla.
- Cuenta con los dedos. Se le queda lo que oye.
- Cuando oye palabras nuevas, pregunta qué quieren decir. No le gusta que le pongan a hacer lo que no quiere. Conoce cinco colores.
- Conoce la forma y tamaño de las cosas.
- Quiere saber que trabajos hacen las personas mayores. Hace muchas preguntas.



Actividades

- Enseñarle a brincar cuerda, a llevar un vaso con agua y a tirar y recibir una pelota.
- Ponerle a contar piedrecitas, maíces o frijoles.
- Mostrarle varios colores y pedirle que diga el nombre de cada uno.
- Enseñarle a conocer los animales las frutas y las comidas.
- Enseñarle pequeñas canciones.
- Pedirle que diga qué forma y tamaño tienen algunas cosas.
- Enseñarle a contestar preguntas fáciles.
- Enseñarle a cumplir normas familiares.



Cuidados

- Poner atención y escucharlo.
- Contestarle sus preguntas en forma sencilla, real y claro.
- Hay que platicarle mucho para conocer lo que quiere y lo que le gusta.

Tener hora para acostarse. Tener un lugar para su ropa. Tener lugar para los juguetes.

- No tratar mal ni con palabras, ni con hechos.



Juguetes y Materiales

- Todos los anteriores, hasta que el niño los abandone.
- Tambores y pitos.
- Otros juguetes con los que pueda jugar de varias maneras.

El Niño de 5 a 6 Años.



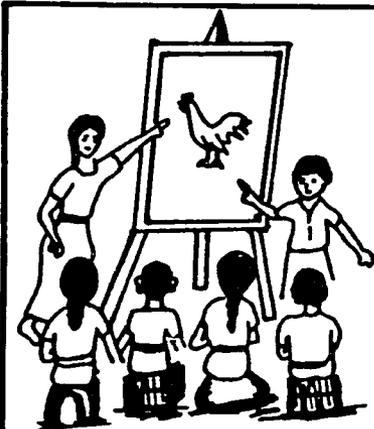
Crecimiento y Desarrollo

- Se sube a árboles pequeños.
- Baila cuando oye música.
- Puede tirar y recibir una pelota. Ya habla bien.
- Cuando dibuja personas, les pone todas las partes del cuerpo.
- Entiende qué indica: izquierda y derecha, ayer y mañana. Pregunta qué quieren decir las palabras que no entiende.
- Quiere saber cuántos años tienen las personas.
- Conoce lo dulce, lo solado, lo ácido y lo amargo.
- No le gusta que lo manden.
- Le gusta hacer trabajos fáciles.



Actividades

- Enseñarle a correr y a brincar lo más alto que pueda.
- Enseñarle a caminar sobre una viga tirada en el suelo, procurando que mantenga el equilibrio.
- Procurar que cuando vea las cosas, se fije bien cómo son.
- Contestar a todas sus preguntas, sin decirle mentiras.
- Dejarle que haga oficios de la casa, pero que no sean peligrosos.
- Enseñarle que los mejores juguetes son los que el mismo hace.



Cuidados

- En esta edad quiere aprender bastante. Por eso le gusta buscar y mirar cosas nuevas.
- Hay que cuidarlo, entonces para que no se haga daño.



Juguetes y Materiales

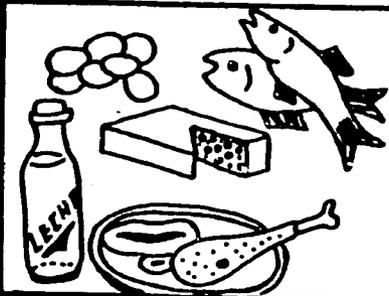
- Dejar que escoja sus juguetes, procurando que éstos lo ayuden a desarrollar su cuerpo y su mente.

Nutrición



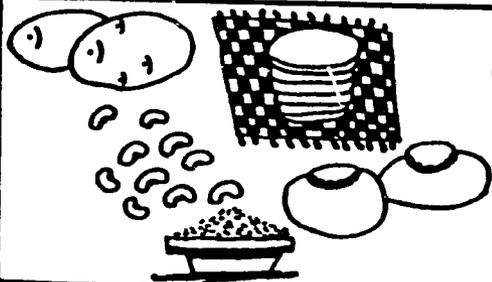
Nutrirse es comer alimentos que mantengan la vida del cuerpo y no sólo que llenen el estómago o se sientan sabrosos, nutrirse es que el cuerpo aproveche lo más que pueda los alimentos que se comen.

Cada alimento que se come ayuda al cuerpo en varias formas, pero hay una forma a la que se dedica más, por eso los alimentos se dividen en 3 grupos así:



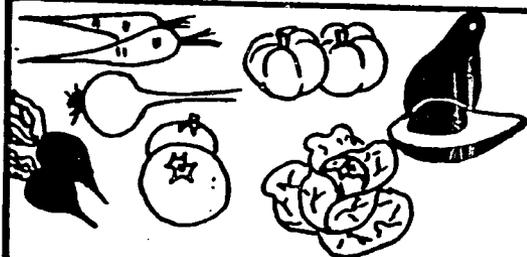
Proteínas: forman, hacen crecer y reponen el cuerpo, estos alimentos son:

manía,	pepitas de ayote,	carnes de todo animal,
incaparina,	quicoy,	la leche, y
arveja,	chilaca yote,	el queso.
soya,		



Carbohidratos: dan fuerza al cuerpo para hacer actividades. Estos alimentos son:

granos y raíces: maíz, arroz, frijol, papa,
plátano, fideo, mosh, maicena.
las grasas: aceite, manteca, mantequilla.



Vitaminas y Minerales: cuidan la salud, estos alimentos son:

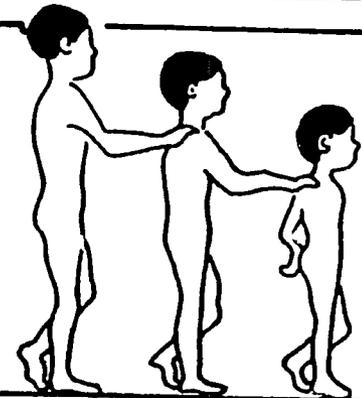
Todas las frutas: banano, manzana, ciruela, jocote etc.

Todas las verduras: quicoy, zanahoria, hojas verdes, etc.

Estos tres grupos de alimento apoyan las tres funciones básicas del cuerpo humano que son:

1. Formarse, crecer y reponerse o mantenerse:

Esta función del cuerpo queda muy bien explicado si recordamos que la concepción de un niño es la unión de dos células muy pequeñas y el niño al nacer mide de 50 a 55 centímetros; pesa de 6 a 8 libras y trae todos sus sentidos y órganos.

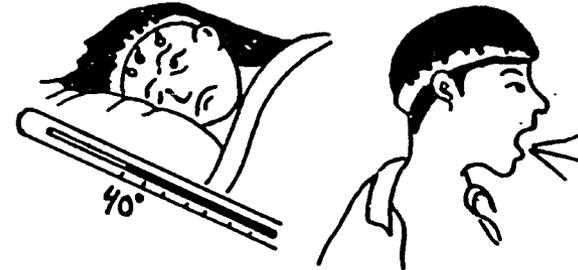


2. Tener Fuerza



Para realizar todas sus actividades de acuerdo a su edad.

3. Defenderse de las Enfermedades.



El cuerpo siempre está defendiéndose de los microbios que entran por la boca y la nariz, si el cuerpo no tuviera la función de defenderse pasaría la mayor parte de su vida enferma.

Para que el cuerpo cumpla sus Funciones es muy Necesario una Alimentación Nutritiva

78 Los Problemas Nutricionales que hay son:



A continuación hay consejos sobre la comida directamente, pero esto no es toda la solución a los problemas de nutrición.



Alimentación del Niño en su Primer Año de Vida:

El niño es muy delicado durante el primer año de vida, depende completamente de sus padres; porque no puede caminar, hablar y alimentarse por sí mismo; por eso es necesario atenderlo cuidadosamente respecto a su alimentación y limpieza.



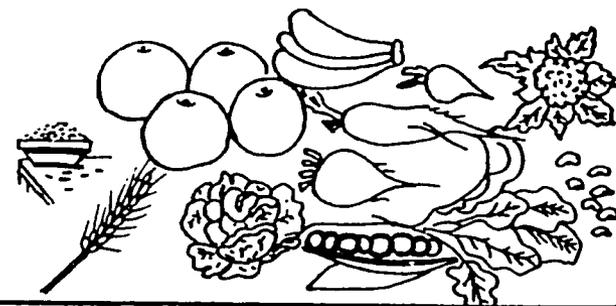
Los Primeros 4 a 6 meses: al nacer el niño, hay que ponerlo a mamar lo más pronto posible. No hay que desperdiciar la primera leche, porque ésta es mejor que lo demás: durante los primeros 4 meses, dele al niño leche de pecho nada más.

La leche materna es el alimento más completo y limpio que existe, es mejor que cualquier alimento que se compra por lo nutritivo y porque es un medio de comunicación, amor y seguridad entre la madre y el niño. Proteje al niño contra la diarrea y otras enfermedades infantiles.



Si la madre no tiene suficiente leche debe tomar bastante líquido, comer mejor y poner al niño a mamar más seguido. Si esto no le ayuda, darle leche de vaca o de cabra, purés o atoles. Recuerde que el niño debe comer proteínas.

La leche materna: es capaz de cubrir todas las necesidades alimenticias del niño hasta los 6 meses de edad; pero a los 4 meses hay que comenzar a darle jugos y purés de frutas, verduras, cereales e incaparina, para que vaya conociendo otros sabores y esté listo a los 6 meses a comer 3 veces al día; además de seguir mamando.



Los alimentos a los 4 meses se preparan molidos, coladas o machucados. No es necesario utilizar pacha, es mejor usar taza y cuchara.



Si el niño tiene asientos, calentura o gripe, hay que seguir alimentándolo normalmente, no hay que quitarle su bebida, comida y la leche para que no pierda su fuerza y se mejore más rápido; lo que si hay que evitar es aceite y manteca, especialmente si tiene diarrea.



Una forma de ver si la alimentación del niño está bien es que siempre está aumentando de peso, cada mes que pasa debe pesar más que el mes anterior, nunca igual ni menos; como regla general debe ser así: a los 5 meses aumenta el doble de su peso al nacer; al año aumenta 2 veces su peso al nacer.
Ejemplo: al nacer pesa 6 libras; a los 5 meses pesará 12 libras y al año 18 libras.



¡ Cuidado con los malos hábitos alimenticios!



Muchos padres de familia acostumbran a sus hijos antes del año a comer solo galletas, aguas gaseosas, frescos de fresquitop, fruty-fruty, risitos etc. muchas veces porque estas cosas entretienen al niño ya que los padres no pueden hacerlo con juegos y la atención necesaria.

Otros padres demuestran el cariño, comprando alimentos caros porque creen que son más nutritivos, pero esa idea no es cierta, ese tipo de alimentos preparados no son necesarios en lugares en donde se cosechan frutas y verduras.

Estos malos hábitos van contra la alimentación adecuada del niño, contra la economía del hogar y contra la salud en general.



Después de un año de edad el niño puede comer las mismas cosas que los adultos, pero se le debe aumentar la proteína si es posible: incaparina, frijol, soya, leche, queso o carne, porque está creciendo rápidamente; además la mayoría deja de mamar a esta edad.



No acostumbrar a los niños a comer cosas dulces porque pierden el apetito y también se pudren los dientes. Ahora cuando la comida es muy escasa, es recomendable mezclar un poco de azúcar y aceite vegetal en los alimentos, porque ayuda al niño a aprovechar más las proteínas que come. Si al niño le dá hambre entre comidas, dele algo nutritivo como frutas, huevo y no dulces o golosinas.

Alimentación del Niño Después de 1 Año: darle alimentos que reponen, que dan fuerza y que
dejienden el cuerpo; también es muy necesario la limpieza.

81

Entre uno y diez años; es muy común que el niño tiene un susto y después de este susto le da el mal del pelo espinado o (Yish wi).
Lo que sucede en estos casos es que el niño tiene desnutrición y tiene desde antes señales que no le damos importancia como:

Bajo peso, según su edad y tamaño.



Poco pelo y sin brillo.



Palidez



Pasividad,
Irritabilidad.



En este momento tiene el susto y lo único que aumenta a las señales anteriores es la falta de hambre, el pelo parado y algunas veces inchazón.

Bibliografía

1. Programa de Promotores de Salud "Materno Infantil", Cursillo 4, Jacaltenango. Huehuetenango, Guatemala 1978.
2. Eosken Fran P. William Marcia L. "Libro Universal de Ilustraciones Del Parto" Publicado por Women's International Network News 187 Grant st. Lexington, Ma. 02173 USA.
3. David Werner "Donde No Hay Doctor", México, Editorial Pax - México, 1975
4. Gally, Esther "Manual Práctico para Parteras", México Editorial Pax - México 1977.
5. Estimulación Temprana UNICEF Guatemala.
6. By Ina May Gaskin "Spiritual Midwifery" © 1980 The Book Publishing Company All Rights Reserved. Summertown, TN 38483 USA.
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