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GUATEMELAN

HIGH RISK BIRTH STRATEGY SEMINAR

AND FOLLOW-UP

A Report Prepared By PRITECH Consultants:
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I. BACKGROUND

A. Relevant Statistics

The importance of working with Traditional Birth Attendants (TBAs) derives from the changing nature of infant mortality in Guatemala. At present it is estimated that 31% of infant mortality occurs in the neonatal period. If the definition of infant mortality were expanded to include all mortality from 28 weeks gestational age (at which time extra-uterine survival of the infant is possible) to one year of life, then close to 50% of all infant mortality would occur prior to one month of age. In Santa Maria de Jesus, Dr. Al Bartlett found that 7.3% of all births were still births, and that the majority of these were associated with malpresentations, prolonged labor and premature rupture of the membranes. These are events which, if properly managed, can usually result in the birth of a live infant. Since TBAs are the principal health providers for rural Guatemalan women in the prenatal, birth and postnatal periods, any efforts at lowering perinatal and neonatal mortality and, thereby, infant mortality must increasingly take TBAs into account.

B. 1989 PRITECH REPORT ON TBA TRAINING AND PRACTICE IN GUATEMALA

The impetus for AID's current efforts in stimulating, coordinating and expanding TBA activities and training resulted from the 1989 PRITECH report *TBA Training and Practice in Guatemala.* The authors of that report called upon USAID/Guatemala to attempt to set in motion a process of change in the area of TBA training and practice. (See Annex C for Executive Summary of report) As this current report will describe, we believe that that process has begun.

II. CURRENT STATUS OF TBA ACTIVITIES IN GUATEMALA

A. Significant Activities in 1989/Early 1990

1. New MOH Manual for TBA Trainers

In 1989, the Division of Maternal/Infant Health in the Ministry of Health produced a new manual for TBA trainers. The manual, which represents a 180 degree turn around in the MOH's approach to TBA training, emphasizes respect for traditional birthing practices and moves in the direction of participative training. At the present time, no concrete plans have been developed for the manual's use and distribution. The manual is an excellent technical resource for trainers. However, in order for it to have an impact, it needs to be complemented by training in innovative/participative training technologies and backed up by obstetrical knowledge, expertise and experience for the trainers.

2. *Quetzaltenango Project*

This INCAP investigation being managed by Dr. Barbara Sheiber has provided a basic understanding about high risk birth events and their management at all three levels of the health care delivery system (community/TBA, health center/health post and hospital). The intervention phase of the project (scheduled to begin by June of 1990, with financing from the MotherCare Project), has been designed and will be implemented based on information gathered during the investigation phase.

The intervention phase involves the MOH at the health area level extensively in all phases of the project and includes a large baseline data collection and evaluation component.

3. *Santa Maria de Jesus Project*

The principal contribution of this project has been to provide the epidemiological basis for:

1. The recognition of the important contribution of perinatal/neonatal mortality to infant mortality (approximately 50% of all infant mortality in Guatemala).

2. The understanding of the causes/etiology of the infant mortality and the impact of appropriate interventions (actual and potential).

While the investigative phase has been largely an INCAP activity, efforts are currently underway to involve the area MOH staff in all phases of the planned project interventions.

4. *UNICEF Huehuetenango Project*

The UNICEF project has developed, tested and documented an innovative approach to working with TBAs by involving them in the development of their own training program. A key factor of this program has been that almost all of the training activities have been conducted in the TBAs' indigenous languages. The MOH, at the health center level, has been extensively involved in all phases of the project level and plans have been made to expand the project into the three health areas of San Marcos, Quiché and Huehuetenango.

Two outstanding videos have been produced through the project. These videos, intended for health professionals and other persons interested in or involved with TBAs, present the comadronas' practices and important role in the Guatemalan Highland culture, as well as demonstrating participatory training techniques in action.

In addition to the videos, the project has tested and produced culturally appropriate training materials, which could potentially be very useful to other projects working with TBAs in highland areas of the region.

5. *Francisco Marroquin University Project*

Within the past year, the Francisco Marroquin University TBA Project has opened up a self-financed "birth center/health post" in a small village, approximately 15 minutes north of San Juan Sacatepequez. The center, which has three beds, plus a "birthing room", is overseen by a staff physician, with at least one medical student usually in residence.

TBAs are not only encouraged to refer prenatal/obstetrical complications to the center, but also, they are welcome to attend any of their clients' births at the center free of charge (unless medications or food are given).

Other general health problems are seen at the center, in addition to births (the consultants observed a young boy being treated for typhoid during the field visit). The next level of referral is Roosevelt Hospital in Guatemala City. Patients are not charged for examinations by a nurse or physician, nor for use of the birth center for deliveries. Medications (including IVs) are sold to patients at below local pharmacy costs and there are nominal charges for meals provided at the center, although families may bring their own food.

III. HIGH RISK BIRTH STRATEGY SEMINAR AND FOLLOW-UP

A. Overview of Seminar

On March 9, 1990, a high risk birth seminar was held at the Hotel El Dorado in Guatemala City. Participants included representatives of the Ministry of Health, Project Concern, UNICEF, APROFAM, Francisco Marroquin University, MSH/Guatemala, PRITECH and AID (see Annex A for a complete list of participants and agenda). The objectives of the seminar were to: Inform participants about some existing, dynamic and successful TBA program in Guatemala, Discuss recommendations included in the 1989 PRITECH study and to develop and prioritize a final list of recommendations for the practice and training of TBAs with strategies and priority actions if possible.

The seminar succeeded in its first objective which was accomplished through presentations by the MOH of its manual, by UNICEF of its participatory training program and its video tapes, by the University Francisco Marroquin of its integrated program and by INCAP of its epidemiological studies in Santa Maria de Jesus. Discussions were lively and broad ranging. When it became obvious that the other two objectives of the meeting were not going to be achieved because of lack of time the group decided that all interested parties would meet again at UNICEF on March 20 to make recommendations concerning the development of a comprehensive program. This is particularly significant because with this decision the initiative of developing a national TBA

program moved out of AID's hands and into those of a national, multi-institutional body and, at the same time, a process of developing national policies and programs was set into motion as had been suggested in the Putney and Smith Report.

B. Follow-up Meetings

On March 20 the first follow-up meeting was held at UNICEF. That meeting was chaired by Dr. Carlos Andrade of the Francisco Marroquin University and attended by representatives of UNICEF, the MOH, APROFAM, AID and PRITECH. It succeeded in developing a draft set of recommendations for presentation by the group to the Ministry of Health. A second meeting was held at UNICEF on March 23 and reviewed and revised the draft report. More significantly, a plan of action was decided upon by the group. That plan determined that, as a first step, a completed set of recommendations should be sent to the MOH at the policy-making level. (See Annex B for the final set of recommendations.) The recommendations suggest that the MOH and donors establish a Technical Advisory Group to monitor, advise and carry forward the process of designing and implementing a national TBA program. Important considerations regarding that TAG are included below.

IV. SIGNIFICANT ISSUES

A. Composition of the Technical Advisory Group

The consultants recommend that the TAG be composed of persons with the following qualifications:

Epidemiologist/Perinatologist
Specialist in Innovative Training Technologies
Anthropologist/Community Participation Expert
Physician (Obstetrician) with TBA Practice Experience
Health Systems Specialist
Nurse-Midwife with TBA Experience
Ministry of Health Representative/s
Others with Relevant Experience

The group should be limited to no more than ten persons.

The consultants recommend the following as the scope of work for the group:

TAG SCOPE OF WORK

■Design the overall TBA program and search for funding.

■Provide on-going coordination, assistance, evaluation and communication in all TBA activities country-wide.

■Promote recognition and appreciation of the TBA as the most important link into the community for reducing maternal/infant mortality.

B. Constraints/Caveats

The potential constraints/caveats are:

■Turnover in the MOH and new government of Guatemala may well disrupt the process of developing a TBA program. This, however, speaks even more strongly for the development of the TAG. Such a group, not being strictly an MOH dependency, will be able to provide continuity to the process over time.

■Utmost care must be taken in the selection of the TAG. Choices should not be made based on assuring the representation of specific interest groups nor on political affiliation, but rather entirely upon technical skills and experience.

■The TAG will need a clear scope of work (see above).

■The TBA program needs to be implemented in a phased approach, with each step built on the previous one and directed simultaneously at the three levels of the health care delivery system (hospital, health center/health post and TBA/community levels).

■A long term commitment and vision is needed for program impact to be measurable.

■Measures need to be taken to thwart competition and sustain a "built-in" spirit of cooperation and collaboration between groups/individuals working with TBAs.

■It is critical to avoid having a monolithic "there is only one way" approach. Innovation and experimentation need to be fostered and encouraged.

■Care needs to be taken to focus on the purpose of TBA activities (ie; the improvement of maternal/child health), so as to avoid seeing these activities as ends in themselves.

C. Recommended Courses for Action

The following are recommended courses of action for USAID/Guatemala:

1. USAID should notify the MOH of the existence of on-going support for TBA activities through the MotherCare project and other sources, if available.

2. The TAG activities should be funded to insure its effectiveness. It was agreed by all that the TAG participants be paid for their time and that we not depend on volunteers.

3. USAID should congratulate the MOH for the approach it is taking to TBA activities and continue to encourage and facilitate the process, without taking it over.

4. USAID should continue to communicate directly and openly with the TAG and the MOH regarding AID's time frames, expectations, needs and constraints.

5. A long term and open-ended approach to the problem of TBA practice and training (to the extent possible) needs to be taken by AID, recognizing that a dynamic and creative process has been set in motion, some of whose final results are at present, not foreseeable.

6. Recognizing that the medical community needs to be neutralized, if not won over, the current opportunity provided by Dr. Rolando Figueroa's interest/leadership, as the President of AGOG, should be capitalized upon in the near future to the fullest extent possible.

A P P E N D I C E S

ANNEX A

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AGENDA

8am	Inscripción
8:30	Apertura

DISCUSIONES DE ALGUNOS PROGRAMAS ACTUALES EN GUATEMALA

9:00	Ministerio de Salud
9:30	UNICEF
10:00	*COFFEE BREAK*
10:15	INCAP
10:45	Universidad Francisco Marroquin

REPASO DEL INFORME PRITECH

11:15	Informe: "La Capacitación y Practica de las Comadronas Tradicionales en Guatemala"
12:30pm	*ALMUERZO*

SESIONES DE TRABAJO

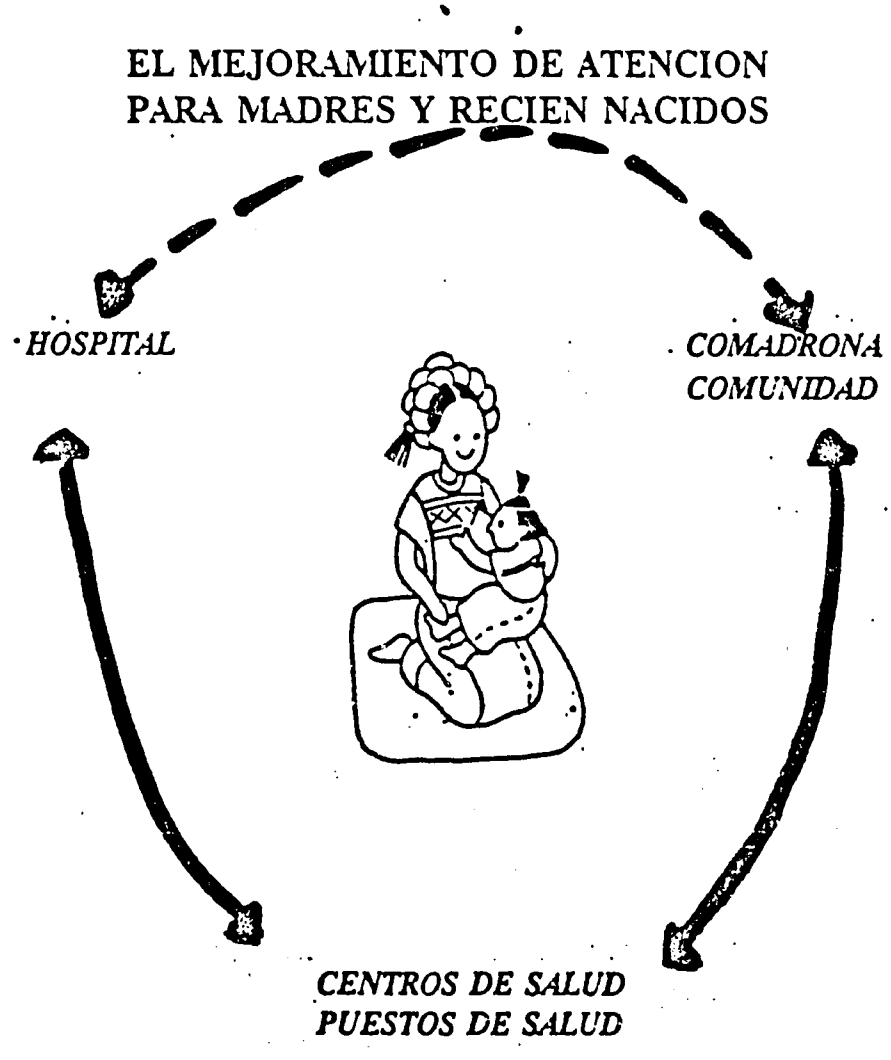
1:30	Grupos de Trabajo
	1. Practicas y Capacitación de Comadronas
	2. Vinculos entre la Comunidad y el Sistema de Salud
	3. Politicas, Apoyo y Administración de Programas de Maternidad Sin Riesgo
3:00	Presentación y Discusión de Grupos
5:00	Clausura

OBJETIVOS DEL TALLER

1. *Discutir las recomendaciones incluídas en el Estudio de Práctica y Adiestramiento para Comadronas PRITECH 1989.*

2. *Informar a los participantes sobre algunos programas actuales para comadronas en Guatemala que son inovadores y exitosos.*

3. *Desarrollar y priorizar una lista final de recomendaciones acerca de las prácticas y el adiestramiento para comadronas, incluyendo si es posible, acciones prioritarias y estrategias de implementación.*



REFERENCE POINTS FROM MEETING
(problems identified)

1. THE REFERRAL SYSTEM (LINKS)

   a. Attitudes

   b. Geographic isolation

   c. Cultural isolation

   d. Lack of basic knowledge of health care providers to deal with high risk events (no standards of care)

   e. Lack of participation by MDs and other competent professionals in TBA training. Comadronas know how to do normal deliveries, what they need is skilled help in dealing appropriately with complications.

   f. If MDs participate in TBA training, the likelihood increases that their attitudes towards TBAs will become more positive. However, they need to be "oriented" before working with TBAs.

   g. Units of support at the district level need to be built.

   h. Need health education in the community.

2. TRAINING AND PRACTICES

   a. Harmful practices identified need emphasis (oxytocin, early pushing, drinking alcohol in labor)

   b. Training should be culturally appropriate and trainers need knowledge about the culture of the groups they are working with.

   c. Training methodologies should be participative.

   d. The most capable TBAs should be trained as trainers.

3. POLITICAL

a. Need adequate information/supervision/evaluation systems.

b. Working with the medical community (AGOG) is a priority.

c. The MOH leadership needs to be convinced that TBA/SafeMotherhood activities are a priority.

d. Pre-Service training for MDs and nurses needs to be carried out. (MD model in Francisco Marroquin University)

e. Inter-Agency coordination is a priority.

f. Sales of oxytocin in the community should be controlled/stopped.

ANNEX B

I. PRACTICAS Y CAPACITACION DE COMADRONAS

1. Para proteger la salud de la madre y del recién nacido, las comadronas realizan las siguientes funciones:
- Control prenatal: donde la tarea es identificar problemas y referirlas al nivel inmediato.
- Asistir parto y recién nacidos: identificar complicaciones y referirlas.
- Dar asistencia a la madre y recién nacido el primer mes postparto.

No se recomienda agregar más funciones a las descritas, debido a que éstas aún no son desarrolladas a cabalidad.

2. Se recomienda tener como marco de referencia para la capacitación el uso de las normas actuales, debiendo estos revisarse y adecuarse a los requerimientos del nivel operativo.

3. Capacitación

A) Universo a capacitar es toda persona comunitaria que haya atendido más de cuatro partos.

B) Contenido: son en base al perfil epidemiológico que las comadronas presentan con el cual identificaron los problemas más frecuentes y sus condicionantes, dándole al facilitador el material para identificar intervenciones.

Quién capacita:

A) Personal previamente capacitado en obstetricia, en medicina y metodología educativa, y que identifique y respete a la comadrona como parte medular de un programa de Salud Materno-Perinatal.

B) Para implementar esta recomendación, se hace necesario reestructurar el actual sistema de capacitación, donde la ejecutora es la enfermera de distrito, quien debiera de tener los conocimientos antes descritos, así como de involucrar, capacitar, concientizar y responsabilizar al médico de distrito, el cual en la actualidad participa en una forma parcial y pasiva en esta actividad.

C) Como intervenciones a corto y largo plazo se hacen las siguientes recomendaciones:

1. Revisar los pensum de estudios de las instituciones formadoras de recursos humanos (Escuelas de enfermería y medicina), con el objetivo de fortalecer el conocimiento y cambio de conducta valorizando la obstetricia tradicional, el respeto a la comadrona como agente de salud y la metodología para conducir esta clase de programas.

2. Diseño de un programa de educación permanente dirigido a los responsables de la conducción del programa (Enfermera - Médico del Nivel Hospitalario del Distrito y Auxiliar de Enfermería).

3. Promocionar a través de seminarios y congresos, la participación del médico como parte básica y fundamental para el éxito del trabajo comunitario con la comadrona.

4. Debe de existir una única institución que normatice y coordine las capacitaciones a nivel nacional.

Como capacitar, está comprobado que la metodología tradicional ha sido poco eficaz y eficiente sin provocar cambios de conducta en las comadronas; por consiguiente, se recomienda la educación participativa como herramienta de resolución de problemas. Diálogos de manera informal como colegas con énfasis en resolver complicaciones y ofrecer opciones de solución y tener al mismo tiempo retroalimentación.

Dentro del proceso de enseñanza - aprendizaje, se debe implementar como metodología educativa la supervisión, monitoreo, evaluación e información, y de ésta forma descentralizar los cursos tradicionales, volviéndose un proceso continuo logrando cambio de actitudes, lo que garantiza su continuidad.

II. VINCULO ENTRE LA COMUNIDAD Y SISTEMAS DE SALUD

A) Falta de aceptación y apoyo operacional desde el punto de vista geográfico, económico, cultural y afectivo por los servicios de salud.

B) Falta de apoyo por los líderes de la comunidad.

Para solucionar los problemas enunciados se recomienda: Propiciar la revisión y reestructuración del sistema actual de prestación de servicios Materno - Perinatal para adaptarlas a manera que se brinde el apoyo y aceptación necesarios a la práctica de la obstetricia a nivel comunitario.

III. POLITICAS

Existen politicas a nivel nacional para proteger la Salud Materno - Perinatal, pero lamentablemente las autoridades a nivel de toma de decisiones desconocen la magnitud del problema, y por consiguiente no se le ha dado la prioridad entre los problemas de salud del país, faltándole el apoyo politico y financiero que avale una nueva estrategia de intervención.

RECOMENDACIONES GENERALES

1. Efectuar seminarios - talleres para dar a conocer a las autoridades de salud y personal de las diferentes instituciones administrativas, la situación actual y opciones de solución.

2. Propiciar la creación nacional de comité de la conservación de la Salud Materno - Perinatal.

INFORME DEL TALLER EL PAPEL DE LA COMADRONA EN ESTRATEGIAS PARA EL MEJOR MANEJO DE ALTO RIESGO EN GUATEMALA

INTRODUCCION-ANTECEDENTES:

Para dar a conocer los resultados del estudio. La capacitación y práctica de las Comadronas tradicionales en Guatemala, efectuado por los consultores Pamela Putney y Barry Smith, con el patrocinio de la Agencia para el Desarrollo Internacional se convocó a un grupo de técnicos nacionales y de organismos internacionales a un Taller llevado a cabo el 9 de Marzo de 1990 en la Ciudad de Guatemala.

Del documento elaborado por ambos consultores se reproduce a continuación lo concerniente a práctica de las comadronas y el análisis de dicha práctica. 1

Las prácticas de las comadronas tradicionales (CT) en la actualidad están centradas alrededor del período prenatal, el parto y el período post-natal. Las principales prácticas prenatales son masajes abdominales y la versión externa (esta práctica es activamente desaprobada por el programa de capacitación del MdeS), los consejos sobre dietas que se refieren al uso apropiado de comidas calientes y frías, la ejecución de ritos para asegurar un nacimiento seguro y, en aumento, el hecho de referir a la madre al centro de salud para exámenes médicos prenatales y la inmunización con toxoide tetánico. Hay una gran variación en el número de partos atendidos por las CT por año, variando de unos pocos hasta más de cien. La comadrona proporciona apoyo emocional, masaje abdominal y tés de hierbas para aliviar las molestias del trabajo de parto. Una vez que la presión perineal es sentida por la madre, la comadrona la incita a pujar.

1. Putney, Pamela - Smith, Barry. La capacitación y práctica de las comadronas tradicionales en Guatemala. Proyecto PRITECH, MSH. Guatemala, Febrero 1989.-

Un creciente número de comadronas están usando oxitocina inyectable (estimulantes hormonales uterinos) para apresurar el proceso de parto. El nacimiento normalmente tiene lugar en la casa de la madre estando presente el esposo y la madre no se quita la falda, respetando la modestia tradicional de las mujeres Mayas. La posición preferida para el parto continúa siendo en cuclillas o de rodillas a pesar de que se les ha enseñado otra forma de hacerlo en los cursos de capacitación. El bebé es recibido por la comadrona en una toalla limpia y puesto a un lado hasta que la placenta es recibida. Una vez que ha salido la placenta, la comadrona corta el cordón umbilical con tijeras (a menudo se leen augurios acerca de la vida del niño y el número de bebés que la madre tendrá en el cordón y la placenta). Las tijeras a menudo no son esterilizadas apropiadamente. Muchas comadronas continúan cauterizando el cordón con una candela, aún cuando esta práctica es desaprobada por los programas de capacitación. Una vez que el cordón es cortado, el bebé es lavado (bañado) y fajado, y generalmente es puesto al pecho de la madre. Después del parto el abdomen de la madre es fajado. La comadrona hace varias visitas postnatales, haciendo masaje al útero y a menudo participa en un baño de vapor y una comida ritual al final del período de convalescencia.

Se estima que hay aproximadamente 20,000 comadronas en Guatemala de las cuales, alrededor del 70% están capacitadas. Aunque el reporte no examina la práctica de partería entre la población ladina, estudios previos han mostrado que en contraste con la población Maya, la población ladina prefiere que el parto se realice en un hospital y la comadrona ladina está en una posición de menos respeto que su contraparte Maya. A pesar de información anecdotal de lo contrario, los autores no pudieron encontrar una confirmación acerca de la impresión que las comadronas tratan otras enfermedades que no están relacionadas con el embarazo. La mayoría de las comadronas reciben pago pago por sus servicios en efectivo o en especie. El pago promedio varía de 3 a 20 Quetzales. Entre la población

Maya, el reclutamiento sobrenatural de la profesión de comadrona continúa siendo común. La mayoría de las comadronas han atendido varios partos previo a la asistencia a los cursos de capacitación. Las comadronas no capacitadas son identificadas a través de contactos con las madres en las clínicas de salud y a través de la revisión de los registros municipales. Las comadronas son invitadas por el Ministerio de Salud dependiendo de los fondos disponibles. Cada comadrona recibe un estipendio de Q. 75.00 por los 15 días que dura el curso. Además, se supone que cada comadrona recibe un equipo de partería por parte de UNICEF, el cuál actualmente sólo contiene tijeras, dos yardas de tela muselina y una balanza con peso en kilogramos.

Una de las áreas más importantes y difíciles a que se refiere el reporte es con respecto a la efectividad de las comadronas y de sus programas de capacitación. La única información disponible es aquella reunida por la Universidad Francisco Marroquín en una municipalidad. Esa información, sin embargo, proporciona evidencia que la capacitación de comadronas hace impacto no solamente en las prácticas de asistencia tradicional de partos, sino también en las tasas de mortalidad.

El eje alrededor del cuál un programa efectivo para parteras gira, es la identificación, referencia y el manejo institucional apropiado de embarazos de alto riesgo. Existen serias barreras culturales, geográficas y emocionales con respecto a la referencia de pacientes.

Además del Ministerio de Salud, un gran número de organizaciones no-gubernamentales e internacionales apoyan las actividades de la capacitación de las comadronas. La Asociación de Servicios Comunales de Salud (ASECSA)

ya no proporciona capacitación a comadronas, sin embargo, ASECSA ha publicado uno de los mejores manuales de asistencia tradicional de partos. En el Proyecto "Project Concern International" en Santiago Atitlán, la capacitación de las comadronas juega un papel muy importante, así como también en la Clínica Maxeña en Santo Tomás, La Unión, Suchitepéquez. El uso de profesionales y promotores indígenas para la capacitación y supervisión distingue estos programas. Proyecto Hope ha incluído durante mucho tiempo la capacitación a las comadronas y la supervisión en su iniciativa de Supervivencia Infantil en Quetzaltenango y San Marcos. El Hospital Maryknoll en Jacaltenango, Huehuetenango será el lugar en donde se realizará una iniciativa financiada por UNICEF para un mejor entendimiento de las creencias y prácticas que sostienen las prácticas tradicionales y por lo tanto permiten el desarrollo de programas de capacitación, las cuales mantienen o sostienen más que destruir esas prácticas. La Escuela de Medicina de la Universidad Francisco Marroquín tiene uno de los programas de comadronas tradicionales más efectivo y mejor estudiado. Toda la información sobre efectividad en este reporte proviene del excelente sistema de información de ese programa. INCAP tiene varios esfuerzos de información en camino. El de más largo alcance es el que se está llevando a cabo en Quetzaltenango, el cual será el vistazo más comprensivo y organizado a las comadronas tradicionales y a las prácticas institucionales con respecto al manejo de embarazos de alto riesgo. Donantes incluyendo a UNICEF, UNFPA Y AID trabajan en gran parte a través del Ministerio de Salud, aunque también han proporcionado fondos a algunas organizaciones no gubernamentales. Por lo tanto, prácticamente no ha habido cooperación interagencial.

Los autores creen que ha sido inapropiado y se ha ocasionado daño el haber tratado de aplicar sin hacer más averiguaciones, un modelo de nacimiento

basado en un hospital urbano occidental en la capacitación de las comadronas tradicionales. Un problema adicional identificado es la brecha entre las metas de capacitación afirmadas y la capacidad del MdeS para alcanzar esas metas. Las limitaciones incluyen restricciones presupuestarias, un sistema inadecuado de referencia y relaciones interpersonales pobres entre algunos profesionales del MdeS y las comadronas, así como la comunidad. Los autores creen que el actual curso de capacitación de 15 días es demasiado dedáctico, complejo y seco para esta gran cantidad de población analfabeta y en su mayoría mujeres del área rural, de avanzada edad. Otro obstáculo para la capacitación es que muchas de las comadronas tienen más experiencia que las enfermeras que les enseñan, con relación a la experiencia de partos en casa. Esto debilita la credibilidad del capacitador y ciertamente baja su confianza en acercarse al asunto objeto de estudio de una forma creativa, informal y espontánea.

El contenido de la capacitación es analizado en relación a su impacto sobre la práctica de las comadronas tradicionales. La gran reducción del uso del alcohol tanto por parte de las comadronas como de sus pacientes en el trabajo de parto, y la práctica de hacer que las mujeres "pujen" demasiado temprano en el trabajo de parto, son dos de las prácticas tradicionales dañinas sobre las cuales los cursos de capacitación han tenido un impacto positivo. Varias prácticas nuevas y benéficas han sido introducidas a través de los programas de capacitación, incluyendo el lavado de las manos, selección de los casos de alto riesgo y su referencia, consejos sobre nutrición, la aplicación de la vacuna del toxoide tetánico y atención mejorada al recién nacido. Desafortunadamente, tres prácticas tradicionales positivas han sido desaprobadas vigorosamente por los capacitadores: la posición de parto vertical, versión externa en el caso de mala posición del feto y la cauterización del cordón umbilical. Varias

prácticas "neutrales" o de algún modo beneficiosas son discutidas, y a menudo desalentadas en los programas de capacitación. Estas incluyen el uso del tradicional baño de vapor ("temescal"), el uso de hierbas medicinales, los masajes pre-natales y post-natales y el fajamiento abdominal. La nueva y esparcida práctica de la aplicación de inyecciones intramusculares de estimulantes hormonales uterinos (oxitócicos) es muy perturbante. Evidencia preliminar sugiere que a ello se debe el aumento significativo de muerte fetal intrauterina. Finalmente, tanto el uso del equipo para comadronas tradicionales tales como los proporcionados por UNICEF como la definición de lo que debería considerarse como embarazo de alto riesgo que requiere ser referido a un hospital o centro de salud, son discutidos.

CONCLUSIONES Y RECOMENDACIONES

En este acápite se identificaron tres aspectos necesarios a analizar, como: Prácticas y capacitación, vínculo entre la comunidad y los sistemas de salud y políticas.

I. PRACTICAS Y CAPACITACION DE COMADRONAS

1. Para proteger la salud de la madre y del recién nacido, las comadronas realizan las siguientes funciones:

   - Control prenatal
   - Atención del parto y recién nacido
   - Asistencia de madre y recién nacido en post-parto.

   Básicamente las funciones se desarrollan para identificar problemas y referirlos.

   No se recomienda agregar más funciones a las descritas debido a que éstas aún no son efectuadas a cabalidad.

2. Se recomienda tener como marco de referencia para la capacitación el uso de las normas actuales, debiendo éstas revisarse adecuándose a los requerimientos del nivel operativo.

   Capacitación

   A) El Universo a capacitar es toda persona comunitaria que haya atendido más de cuatro partos.

   B) El contenido debe basarse en el perfil epidemiológico que las comadronas presentan con el cual identifican los problemas más frecuentes y sus condicionantes, dándole al facilitador el material para intervenciones.

   Quién capacita:

   A) Personal que identifique y respete a la comadrona, como parte

medular de un programa de salud materno-perinatal, previamente capacitado y con experiencia en la práctica obstétrica.

B) Para implementar esta recomendación, se hace necesario reestructurar el actual sistema de capacitación, donde la ejecutora es la enfermera de distrito quien debiera tener los conocimientos antes descritos, así como de involucrar, capacitar, concientizar y responsabilizar al personal y médico de distrito, el cual en la actualidad participa de forma parcial y pasiva en esta actividad.

C) Como intervenciones a corto y largo plazo se hacen las siguientes recomendaciones:

1. Revisar los pensum de estudios de las instituciones formadoras de recursos humanos (Escuelas de enfermería y medicina) con el objetivo de fortalecer el conocimiento y cambio de conducta valorizando la obstetricia tradicional, el respeto a la comadrona como agente de salud y la metodología para conducir esta clase de programas.

2. Diseñar e implementar un programa de educación permanente dirigido a los responsables de la conducción del programa (Enfermera - Médico del Nivel Hospitalario y de Distrito y Auxiliar de Enfermería).

3. Promocionar a través de seminarios y congresos, la participación del médico como parte fundamental para el éxito del trabajo comunitario con la comadrona, así como de enfermeras y estudiantes de ambas profesiones.

Como capacitar:

A) Está comprobado que la metodología tradicional ha sido poco eficaz sin provocar cambios de conducta en las comadronas.

B. Se recomienda la educación participativa como herramienta para la resolución de problemas; dentro de ésta actividad que entre otras incluyan diálogos de manera informal, como colegas, enfatizando la resolución de complicaciones y obtener simultáneamente retroalimentación.

C. Se debe implementar, dentro del proceso de enseñanza-aprendizaje, como metodología educativa la supervisión, el monitoreo, la evaluación y la información; de ésta forma descentralizar los cursos tradicionales tornándolos un proceso continuo logrando cambio de actitudes, lo que garantiza su permanencia.

II. VINCULO ENTRE LA COMUNIDAD Y SISTEMAS DE SALUD

En este importante aspecto se identificaron los obstáculos descritos a continuación:

A) Falta de aceptación y apoyo operacional desde el punto de vista geográfico, económico, cultural y afectivo por los servicios de salud.

B) Falta de apoyo por los líderes de la comunidad.

Para solucionar los problemas enunciados se recomienda:

Propiciar la revisión y reestructuración del sistema actual de prestación de servicios Materno - Perinatal para adaptarlo a manera de que se brinde el apoyo y aceptación necesarios a la práctica de la obstetricia en el nivel comunitario.

III. POLITICAS

Existen lineamientos a nivel nacional para proteger la salud Materno Perinatal pero se adolece de mecanismos concretos para operacionalizarlas, mismas que necesitan del apoyo político y financiero que

avale una nueva estrategia de intervención.

Al respecto se sugiere:

1. Efectuar seminarios - talleres para dar a conocer a las autoridades de salud y personal de las diferentes instituciones administrativas, la situación actual y opciones de solución.

2. La trascendencia de la salud materno - perinatal necesita de un grupo técnico asesor permanente, a nivel nacional, que apoye al Ministerio de Salud Pública en el proceso considerándose que los miembros del grupo en mención deben ser seleccionados de acuerdo a su curriculum y solvencia profesional.

3. El Ministerio de Salud Pública, a través de sus unidades técnico-normativas debe ser el que coordine y dirija la actividad de comadronas.

OBJETIVOS

1. Informar a los participantes sobre algunos programas actuales para comadronas en Guatemala que son innovadores y exitosos.

2. Discutir las recomendaciones incluidas en el Estudio de Práctica y Adiestramiento para comadronas PRITECH 1989.

3. Desarrollar y priorizar una lista final de recomendaciones acerca de las prácticas y el adiestramiento para comadronas incluyendo, si es posible, acciones prioritarias y estrategias de implementación.

METODOLOGIA

El desarrollo de la actividad se efectuó básicamente a través de exposiciones dialogadas y plenarias de las cuales se extractaron conclusiones para el consolidado final.

PROGRAMA

8:00	Inscripción
8:30	Apertura

DISCUSIONES DE ALGUNOS PROGRAMAS ACTUALES EN GUATEMALA

9:00	Ministerio de Salud
9:30	UNICEF
10:00	COFFEE BREAK
10:15	INCAP
10:45	Universidad Francisco Marroquín

REPASO DEL INFORME PRITECH

11:15	Informe: "La Capacitación y Práctica de las Comadronas Tradicionales en Guatemala"
12:30	ALMUERZO

SESIONES DE TRABAJO

13:30	Grupos de Trabajo
	1. Prácticas y Capacitación de Comadronas
	2. Vínculos entre la Comunidad y el Sistema de Salud
	3. Políticas, Apoyo y Administración de Programas de Maternidad Sin Riesgo
15:00	Presentación y Discusión de Grupos
17:00	Clausura

PARTICIPANTES

	NOMBRE	INSTITUCION
1.	Andrés Kreßt	USAID
2.	Cristina López de Turri	Departamento Materno Infantil, Ministerio de Salud Pública
3.	Carlos Andrade Lara	Universidad Francisco Marroquín
4.	Jorge A. Solórzano B.	APROFAM
5.	Alfred Bartlett	INCAP
6.	Elizabeth de Bocaletti	INCAP
7.	Barbara Schieber	INCAP
8.	Pamela J. Putney	PRITECH/MSH
9.	Barry Smith	PRITECH/MSH
10.	Miriam de Figueroa	UNICEF
11.	Eliana Arias U.	UNICEF
12.	Susana Lemus	Departamento Materno Infantil, Ministerio de Salud Pública
13.	Rolando Figueroa A.	Asociación de Ginecología y Obstetricia.

ANNEX C

THE TRAINING AND PRACTICE OF TRADITIONAL BIRTH ATTENDANTS IN GUATEMALA

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Submitted to USAID/Guatemala
February 1989

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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 the 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

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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.

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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

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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. She is generally not seen as part of the health care team, but rather as a necessary evil, and not as a valuable health resource.

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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