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BASICS
TRIP REPORT

Incentives for and Barriers to the Adoption of SCM Procedures for Pnuemonia Among Guatemalan Physicians

BASICS is a USAID-Financed Project Administered by
The Partnership for Child Health Care, Inc.

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INCENTIVES FOR AND BARRIERS TO THE ADOPTION OF STANDARD CASE MANAGEMENT (SCM) PROCEDURES FOR PNEUMONIA AMONG GUATEMALAN PHYSICIANS

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ACKNOWLEDGMENTS

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ACRONYMS

ARI	Acute Respiratory Infections (Spanish: IRA)
BASICS	Basic Support for the Institutionalization of Child Survival
IEC	Information, Education, and Communication
INCAP	Nutritional Institute of Central America and Panama
KAP	Knowledge, Attitudes, and Practices
MSPAS	Guatemalan Ministry of Public Health and Social Services
REACH	Resources for Child Health Project
SCM	Standard Case Management (of Pneumonia)
USAID	United States Agency for International Development
WHO/PAHO	World Health Organization/Pan American Health Organization

I. EXECUTIVE SUMMARY

This qualitative study examines physician attitudes and behaviors in terms of their adoption or non-adoption of Standard Case Management (SCM) norms for the diagnosis and treatment of Acute Respiratory Infections (ARI) in children. A total of 41 physicians were interviewed; 19 in in-depth interviews and five, eight, and nine in three different focus groups in Huehuetenango, Zacapa, and Guatemala City.

This study uses epidemiology's case-control logic to assess factors that may lead to a broad adoption of SCM. Physicians are classified as "cases" (adopters) or "controls" (non-adopters), according to their responses to hypothetical cases of how they would respond to various levels of ARI severity in under-fives.

The protocol is divided into seven question categories:

1) What and who are the most credible sources of new information;
2) What information and pressure is received from pharmaceutical salesmen;
3) What incentives and disincentives make SCM adoption more or less likely;
4) What type of training is recommended for new SCM norms;
5) What actions mothers take that hinder appropriate medical actions; and
6) What recommendations physicians have for promulgation of the SCM norms nationally.

In addition, physicians are asked directly about their clinical response to hypothetical cases in order to classify them as "cases" or "controls."

Cases are more likely to work at least part-time in hospitals in a professional environment where modern techniques are supported by peers and allied health professionals. They attend to modern publications where SCM and other techniques are supported. They or their auxiliary staff take time to counter mothers' requests for inappropriate pharmaceutical products. They seek out training opportunities and conferences. They admit, however, that pharmaceutical representatives court them frequently to solicit their use of certain products that may or may not be appropriate for the treatment of ARI.

Controls are more likely to work primarily or exclusively in private practices and/or in rural areas. They infrequently have opportunities for training or conference attendance, and are seldom, if ever, visited by drug salesmen. Most of their information is that which they received in medical school, although some claim to keep up on developments through medical association literature and meetings. They feel that SCM and other norms change too frequently, are too vertical in nature, and do not take into account existing experiences and realities. They have little time to discuss treatment with mothers and may even fear losing their business should the mother leave without the prescription she wants. The single major barrier to the adoption of

SCM, especially in the rural areas, is the non-availability (or at least lack of awareness of availability) of appropriate drugs.

Both cases and controls converged in their perceptions of incentives and barrier reductions that might increase SCM-related behavior:

1) More articles and case studies about SCM presented in medical journals and at medical society meetings;
2) Training and reinforcement of auxiliary staff in how to educate mothers about ARI home management;
3) Audio cassettes (in Spanish and indigenous languages) and video cassettes for educating mothers in clinics and hospitals; and
4) Follow-up training with monitoring, reinforcement, and "booster" training.

Two other intervention ideas not proactively suggested by interviewees received endorsement from most of them. First, case studies and publications used to promulgate the norms directly should accent the practices of existing early adopters given the potential efficacy of such role models. Second, mass communication should be concurrently directed at mothers to educate them regarding what treatment to seek, when to seek it, and what treatment not to ask for when their children have ARI.

II. PURPOSE OF THE TRIP

A component of the BASICS effort in Guatemala is to support information, education, and communication (IEC) activities in ARI control. The Guatemalan MSPAS wishes to improve health worker performance through the increased compliance of health workers with established guidelines for standard case management (SCM) of pneumonia. The first step of this endeavor is to research the barriers and incentives that decrease or increase compliance (or non-compliance) of physicians and other heath care workers with SCM.

Therefore, the objective of this trip is part of an overall effort to improve health provider compliance with standard case management of pneumonia. Specifically, the consultants were asked to:

1) Develop and test a formative research protocol for this effort (emphasizing in-depth interviews and focus group activities);

2) Conduct the formative research in the designated areas (Zapaca, Huehuetenango, and Guatemala City, where SCM training is being or soon will be conducted);

3) Tabulate, analyze, and write a report on the results, including possible interventions for behavior modification emphasizing low cost, sustainable, and reproducible techniques using locally available resources, and

4) Develop a presentation for the state-of-the-art workshop which was held in Antigua on October 6 and 7, 1994.

III. BACKGROUND

Acute Respiratory Infections (ARI) are a major killer of children under five years of age, responsible for four million deaths worldwide annually. The majority of these deaths are due to pneumonia. Pneumonia, in turn, is frequently caused by *Streptococcus pneumoniae* and *Hemophilus influenzae*. Although no practical preventive measures currently exist, most ARI can be managed at home, if detected and treated early (Gove and Pelto, 1994).

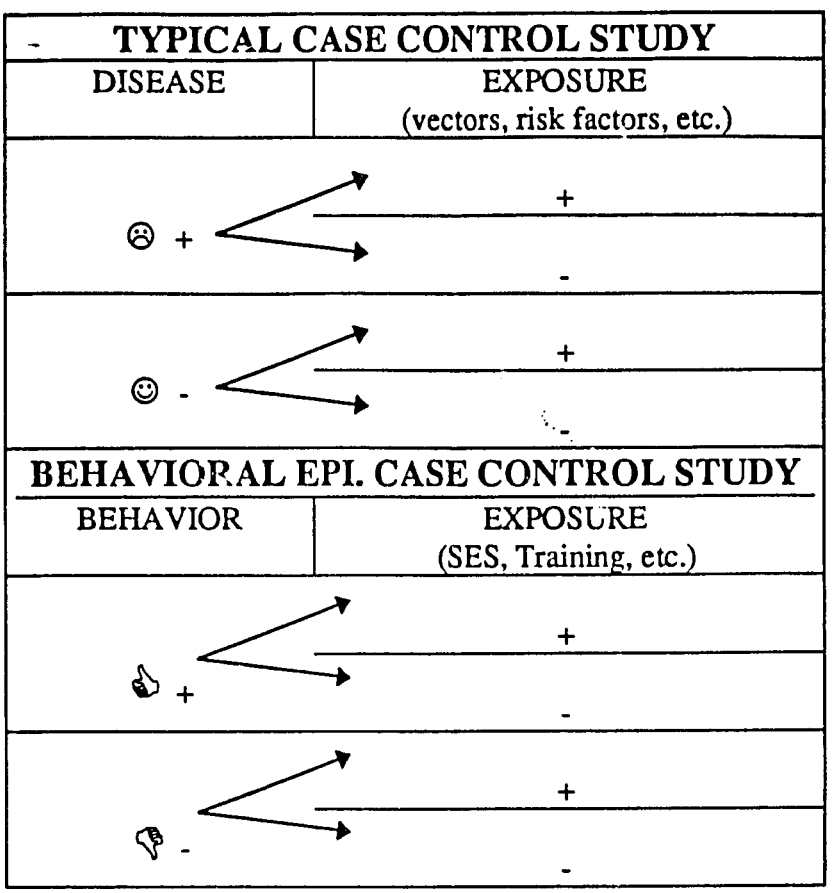
The Ministry of Public Health and Social Services in Guatemala (MSPAS) has an Acute Respiratory Infection Control Program with standard guidelines for treating these cases in children. This study uses qualitative research methods to examine the adherence to standardized case management protocols by Guatemalan physicians. It utilizes study instruments developed by Avila de Hails and Barrera de Martinez (1993) for a similar study conducted in Bolivia for the REACH project. In the Bolivian study, these two researchers found that generally doctors and nurses accept modern ARI norms, but report many barriers nevertheless. For instance, when pressed for time physicians may not argue with a mother who inadvisably wants antibiotics for her child. Home management messages were not reinforced, and physicians still preferred their stethoscopes for "more accurate diagnoses."

Many researchers investigating health behaviors of target audiences and change agents alike emphasize knowledge, attitudes and other cognitive factors relevant to a given target behavior. Hence, the term "KAP" denotes a direct causal link between knowledge and attitudes on one hand and behaviors on the other. Although behaviorists may admit that knowledge and attitudes are important factors, they place a far greater emphasis on environment - behavior interactions that may reinforce certain behaviors and inhibit others (Graeff, Elder & Booth, 1993; Elder, Geller, Hovell and Mayer, 1994). Behavioral psychologists see behaviors as not occurring due either to lack of skills ("skills deficit"), a lack of agreeable consequences, or too many disagreeable ones ("performance deficit") for the behavior.

Although coming from vastly different backgrounds (medicine vs. philosophy/social science), research approaches used by epidemiology and psychology often converge. "Behavioral epidemiology" has now become a commonly used term in chronic disease research, referring to the integration of traditional epidemiological investigation with behavioral assessment, to determine risk- and health-related behaviors distributed in populations. The current study,

although qualitative in nature, uses case-control logic to investigate whether different "exposures" (specialization, recent training, type of practice, motivation, etc.) are potential correlates of whether physicians adopt or do not adopt SCM. (See Figure 1). Most importantly, we seek to identify potential interventions (e.g. training, follow-up, the use of role models, incentives, publications) that can be used to convert non-adopters to adopters.

FIGURE 1



IV. TRIP ACTIVITIES

Field work was conducted in Zacapa, Huehuetenango, and Guatemala City. Zacapa is populated primarily by Ladinos and is located in the southeast lowland region of the country near the Honduran border. Huehuetenango is a largely indigenous region, in the northwest highlands, not

far from the Mexican border. Interviews were conducted with physicians in public hospitals and private clinics in these three areas.

This qualitative study examines physician attitudes and behaviors in terms of their adoption or non-adoption of SCM norms for the diagnosis and treatment of ARI in children. A total of 41 physicians were interviewed; 19 were in-depth interviews, and five, eight, and nine were interviewed in three different focus groups, and three in Huehuetenango, Zacapa and Guatemala City.

This study uses epidemiology's case-control logic to assess factors that may lead to a broad adoption of SCM. Physicians are classified as "cases" (adopters) or "controls" (non-adopters) according to their responses to hypothetical cases of how they would respond to various levels of ARI severity in under-fives. Individual physicians were classified as "cases" if they included most or all of the SCM steps in their responses, and "controls" if none or few of these steps constituted their approach.

The hypothetical case studies were read directly to physicians participating in the in-depth interviews (see Appendix C), after which they gave their individual responses. This direct pedagological approach, however, was deemed inappropriate for the focus group format, given the potential for all participants to develop a consensual rather than individual response to the hypothetical cases. Therefore, general and less direct examples of ARI diagnostic and treatment challenges were presented to the focus groups, with each participant encouraged to respond individually.

The protocol is divided into seven question categories:

1) What and who are the most credible sources of new information;
2) What information and pressure is received from pharmaceutical salesmen;
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4) What type of training is recommended for new SCM norms;
5) What actions mothers take that hinder appropriate medical actions; and
6) What recommendations physicians have for promulgation of the SCM norms nationally.

In addition, physicians are asked directly about their clinical response to hypothetical cases in order to classify them as "cases" or "controls."

V. RESULTS AND CONCLUSIONS

In-depth interview and focus group information yielded approximately the same types and quality of responses. Therefore, the results from the two formats will be combined in this

section. When cases and controls responded similarly to the information, their responses will be summarized together, and presented separately when their responses were different.

A. Credibility and sources of information

No important differences existed between cases and controls on this variable. Both expressed the opinion that scientific and case study-oriented publications and conferences sponsored by WHO/PAHO, INCAP, and the MSPAS were credible and accessible sources of information. In addition, the *Boletin del Colegio de Medicos, Revista del Colegio de Medicos y Cirujanos,* and the *Revista de la Asociacion Pediatrica de Guatemala* were all mentioned and frequently accessed Guatemalan medical publications.

B. Information providers

Although no case/control distinction was forthcoming on this variable, general practitioners felt that medical specialists were the best personal source of innovative information, while the specialists again referred to national and international research experts (WHO, PAHO, etc.) as being the most salient source.

C. Role of pharmaceutical salesmen ("visitadores medicos")

Interesting distinctions occurred between cases and controls on the issue of interactions with promoters of pharmaceutical products. Cases felt that these representatives had a major influence on physicians through use of "slick" print materials, other educational approaches regarding state-of-the-art treatment of ARI, and direct and indirect gifts. (One physician in Guatemala City reported being taken to dinner by different representatives four times in the previous week.) Cases opined that such representatives were especially effective with private physicians.

Controls felt that only physicians with inadequate training or recent information were vulnerable to pressures exerted by pharmaceutical salesmen. They saw the latter as poorly informed except in the use of their proprietary product(s), such as antihistamines and nasal decongestants. Rural physicians reported seldom if ever being visited by these representatives.

D. Standard Case Management for ARI

Cases felt that the SCM promoted by the MSPAS were practical and efficacious, but more relevant to primary rather than hospital care. Resistance to new SCM norms is normal and will diminish over time. The scientific basis for ARI (and all other) SCM is the critical element of any new norms.

Controls saw SCM norms as something of a threat to their "individualism". Whenever the MSPAS or other authorities promote new norms, much effort is put into the initial kick-off with little or no follow up. Norms are derived and promulgated vertically, with little attention given to local experiences. Unlike the cases, the controls felt that a greater emphasis should be put on parallel promotion to nurses and other auxiliary health personnel. Some controls saw the new norms as overly simplified and even patronizing, while others (especially older physicians) were concerned about the lack of integration between these norms and the training they received in medical school.

A few controls distrusted information presented by the MSPAS in general, stating that protocols and norms changed so frequently that they were difficult to take seriously. Finally, rural physicians (i.e. those working in communities with 10,000 or fewer people), even those who had undergone the new training, reported that they were forced to prescribe whatever limited drugs were available locally, no matter what the new norms proposed.

E. Incentives and Barrier Reduction

Responses to this critical variable varied substantially between cases and controls. Cases felt that by using Medical Association meetings to present SCM norms and make them "normative", most individual physicians would respond to the implicit collegial pressure and adopt SCM. Special recognition for research, case studies and improving practice would further reinforce the early adopters and promote vicarious learning among later adopters. Such recognition could be presented through scientific and domestic medical publications, as well as at Medical Association meetings and special conferences. Conferences with expenses paid by the MSPAS or other agency would serve as effective forums for new or follow-up training. The use of newspapers and radio could be used to announce to the public (and potential clients) the names of physicians who have received the training and would therefore be specially prepared for the most advanced clinical response to ARI.

Controls were concerned about the possibility of favoritism or corruption in giving special recognition to researchers and practitioners for ARI work. They recommended that such reinforcement be non-material and expressly for the purpose of promoting the practice among later adopters. An adequate supply of appropriate medicine in rural areas was the single most important barrier reduction among rural physicians. Visitation by experts in hospitals and clinics would be an important incentive to shift normative behavior. Most suggested that follow-up was as or even more important than the initial training per se. Some indicated that changing medical school curricula was more effective than re-educating practicing physicians (and two stated that this future investment is the only effort that held any promise).

F. Diagnostic Methods

In general, cases felt that stethoscopes and x-rays did not serve any important diagnostic function, although some implied that they used them as confirmatory tools. Antibiotic resistance

tests were generally not available, almost universally not understood or used. Among controls, the stethoscope is seen as the single most important diagnostic tool, backed by x-rays where available.

G. Mothers' Attitudes

Mothers using public facilities are forced to do so because of poverty. Such clinics are extraordinarily busy; effective case management involving education of the mothers can only be accomplished if the mother is educated by nurses or auxiliaries. Private physicians take far more time to educate their (paying) clientele, but also are more anxious about losing their patients should they not respond the latter's demand for certain medications.

VI. SUMMARY OF RESULTS

Cases are more likely to work at least part time in hospitals in a professional environment where modern techniques are supported by peers and allied health professionals. They are more frequent readers of modern publications where SCM and other techniques are supported. They or their auxiliary staff take time to counter mothers' requests for inappropriate pharmaceutical products. They seek out training opportunities and conferences. They admit, however, that pharmaceutical representatives court them frequently to solicit their use of certain products that may or may not be appropriate for the treatment of ARI.

Controls are more likely to work primarily or exclusively in private practices and/or in rural areas. They infrequently have opportunities for training or conference attendance, and are seldom if ever visited by drug salesmen. Most of their information is that which they received in medical school, although some claim to keep up on developments through medical association literature and meetings. They feel that SCM and other norms change too frequently, are too vertical in nature, and do not take into account existing experiences and realities. They have little time to discuss treatment with mothers and may even fear losing their business should the mother leave without the prescription she wants. The single major barrier to the adoption of SCM, especially in the rural areas, is the non-availability (or at least lack of awareness of availability) of appropriate drugs.

Both cases and controls converged in their perceptions of incentives and barrier reductions that might increase SCM-related behavior:

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Two other intervention ideas not proactively suggested by interviewees received endorsement from most of them. First, case studies and publications used to promulgate the norms directly should accent the practices of existing early adopters, given the potential efficacy of such role models. Second, mass communication should be concurrently directed at mothers to educate them regarding what treatment to seek, when to seek it, and what treatment not to ask for when their children have ARI.

At least implicit in the responses of both cases and controls was the perception that experienced physicians were perhaps an inappropriate target for promoting new ARI norms. Instead, many suggested that the "new generation" of physicians currently in medical school or residencies would comprise a more malleable target group.

VII. RECOMMENDATIONS

1. Training can only be effective over the long term with boosters and follow up. Training should begin with medical directors and other opinion leaders before being presented to subordinates. Conferences and seminars can serve as effective training formats, but less expensive presentations at regular medical association meetings, distance learning, and publications may prove more feasible.

2. Relatedly, monitoring involving actual monitoring of ARI diagnosis and management, is crucial for determining whether physicians and other health personnel actually perform in these tasks appropriately. The accompanying effort conducted by Salgado, Smith, and Quan provides an excellent prototype for how to carry out such monitoring.

3. It has become a truism that "community involvement" is crucial to adequate, appropriate, and acceptable primary health care. In the case of ARI management, however, some physicians are concerned about the form that such involvement takes. Mothers come to them with sick babies, demanding "drug X" when "drug X" may be inappropriate. Physicians are asking for help in reducing the pressure the community (i.e. mothers) are exerting on them for inappropriate treatment. Such assistance could take the form of mass media information educating the population about what medical assistance to ask for and what not to.

4. Other mothers cannot afford private care and must rely on overcrowded public clinics. In these, physicians have little time to educate mothers and must rely on nurses and

auxiliaries to do so. Videotapes for waiting room educational presentation and audiotapes in local dialects can assist in the educational process. Mothers of infants who are hospitalized should be given the opportunity to "room-in" and learn more about SCM.

5. The pharmaceutical industry should be involved in the effort to promote SCM or at least should not act in ways that negate it.

6. Future research in this area may take on a variety of refinements. First, video presentations of ARI cases may prove more realistic to respondents and may yield more valid responses. Second, experimental evaluations training and/or follow up may include the randomization of physicians and/or other primary health care personnel into intervention/control efforts. Community involvement could be an add-on component, with mothers and others taught to request appropriate treatment, express appreciation for the efforts of their primary health care team, and other forms of involvement promoted via mass communication.

VIII. FOLLOW-UP ACTIVITY REQUIRED

Every effort should be made to follow-up already trained physicians in six to twelve months to provide further encouragement and assist in resolving problems with the new SCM norms.

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APPENDICES

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APPENDIX A

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APPENDIX A
LIST OF CONTACTS

1. Dr. Carlos Mayorga
   Chief of Pediatrics
   Social Security Children's Hospital
   Guatemala City

2. Dr. Rene Salgado
   Dr. Barry Smith
   BASICS

3. Dr. Victor Lara
   Dr. Carlos Quan
   Clapp and Mayne, Inc.

4. Dr. Pat O'Connor
   Dr. Jorge Chang
   USAID-Guatemala

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APPENDIX B

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APPENDIX B

INSTRUMENT USED FOR IN-DEPTH INTERVIEWS AND AS A GUIDE FOR FOCUS GROUPS

Preguntas para la Entrevista a Profundidad

A. Credibilidad de las Fuentes de Información

1. Cómo obtiene información técnica actualizada sobre IRA?

2. Cúales de los métodos de comunicación (materiales impresos, conferencias, etc.) sobre la nueva información a médicos seria mas eficaz?

3. Quiénes son los proveedores sobre innovaciones en IRA de mayor credibilidad para Ud.?

4. En su vida actual profesional, quién es la persona que tiene mayor influencia sobre su practica médica?

B. Visitador Médico

5. Le ha hablado sobre IRA últimamente? El visitador médico. Influye él sobre el o los medicamentos que prescribe en casos de IRA? de qué manera? (si respondió que no, cómo trató de influenciarlo?)

C. Manejo del MEC

6. Generalmente, qué piensa de las normas y protocolos que promueve el MSPAS? Cuáles son las barreras que hay contra la adopción de estas normas?

7. Qué capacitación sobre el manejo de IRA ha tenido ud.?

8. Qué puede hacer el MSPAS para promover cambios en la práctica de los médicos? (Despúes de la repuesta, mencione también premios, invitaciones a conferencias especiales, publicidad de MSP, felicitaciones por radio, reconocimientos en público, etc.). Cuáles de estos serían más poderosos para cambiar la práctica de los médicos?

9. (Lea el estudio de caso de un niño con IRA): Qué haría Ud. con este caso?

10. Las conductas que sigue un médico con relación al MEC difieren si éste las aplica dentro de un hospital de cuando las utiliza en su clínica privada? por qué?

11. Cuáles son los principales problemas que ha encontrado con el manejo del MEC?

12. Cómo piensa que podrían superarse estos problemas?

13. Cómo recomendaría a otros médicos las bondades del MEC?

14. De qué depende las diferencias en cuanto al uso o rechazo del MEC por parte de otros colegas?

15. Qué piensa sobre el uso del estetoscopio y Rayos X como instrumentos de diagnóstico para IRA?

15.a Utiliza algún tipo de examen para medir resistencia antibiótica, cuáles están disponibles, cómo se interpretan, como correlacionan los resultados del examen con el Tx. que prescribe?

E. Opinión sobre el comportamiento de la Madre

16. Cómo piensa que influye la madre sobre las decisiones que toma en cuanto al MEC?

17. Le preocupa que la madre no i confíe en su consejo si no prescribe lo que ella le solicita?

18. Cómo piensa es la relación con la madre en un ambiente público versus uno privado en cuanto al MEC?

19. Qué podría incorporarse en el MEC para convencer a la madre que su niño no necesita antibiótico?

20. Qué recomendaciones haría para mejorar el MEC en cuanto a la resistencia de otros colegas para el uso de MEC? y en cuanto a las resistencias de las madres?

F. Datos Personales:

Especialidad:_____

Lugar de practica:_____

Tipo de practica:_____

Edad:(aproximada)_____

Sexo:_____

APPENDIX C

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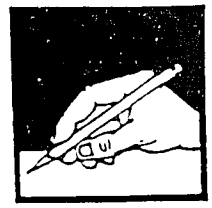
3.

4.

5.

b) Examine la lista anterior y seleccione las dos diferencias entre los grupos de edad que usted considera son más importantes. Haga esto marcándolas con una estrella.

Avísele al facilitador cuando haya terminado este ejercicio.



EJERCICIO E

En este ejercicio, usted leerá la información sobre la evaluación, clasificará la enfermedad e identificará un plan de tratamiento para dos lactantes pequeños. Suponga que usted es un trabajador de salud en una zona urbana. Anote sus respuestas refiriéndose al gráfico de atención de casos que aparece en la página 98, y escribiendo sus respuestas en el espacio proporcionado en esta página.

CASO UNO: María

1. Lea la siguiente información sobre el caso.

La madre trajo a su pequeña bebé, María, al centro de salud porque no estaba lactando tan bien como debía y su respiración era rara. Al hacer preguntas, el agente de salud se entera de que los pechos de la madre están congestionados, y ella cree que María está tomando menos de la mitad de su ración habitual de leche materna. María tiene 13 días de edad y nació después de un parto muy largo y difícil. La madre le dice que el lactante pequeño no ha tenido fiebre. Ella no cree que ha tenido convulsiones, y dice que le resulta difícil despertarse.

La frecuencia respiratoria del lactante pequeño es 62. En la cuenta siguiente, la frecuencia bajó a 55. Tiene ligeramente retraído el tórax y no hace ruido al respirar. Está bien dormido y no se puede despertar, aunque lo sacudan. Le siente la axila y las pantorrillas y observa que no está ni demasiado caliente ni demasiado frío.

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2. Enumere todos los signos de la enfermedad de María en el espacio que sigue:

3. Anote cómo clasificaría la enfermedad de María escribiendo la clasificación en el espacio que sigue. Enumere también los signos que usó para clasificar su enfermedad.

4. Mire el plan de tratamiento bajo la clasificación en la que situó a María, y diga qué haría escribiéndolo en el espacio que sigue.

CASO DOS: Ciro

1. Lea la siguiente información sobre el caso.

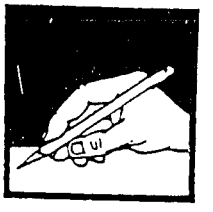
Ciro tiene unas tres semanas de nacido. Su madre lo trajo hoy al centro de salud porque está tosiendo. Ella está teniendo alguna dificultad para amamantarlo, pero todavía puede tomar casi la cantidad normal de leche. Ella dice que lo sintió caliente, pero que no ha tenido convulsiones. Cuando usted examinó a Ciro no observó tiraje ni escuchó ruidos raros cuando respiraba. La primera vez que le contó la respiración, esta fue de 60 veces por minuto. La segunda vez fue de 3[illegible] veces por minuto. Ciro reacciona ante [illegible] voz y lo mira a la cara cuando se mueve frente a él. Tiene una temperatura de 37,8°C.

2. Enumere todos los signos de la enfermedad de Ciro en el espacio que sigue:

3. Anote cómo clasificaría la enfermedad de Ciro escribiendo la clasificación en el espacio que sigue. Enumere también los signos que usó para clasificar su enfermedad.

4. Mire el plan de tratamiento bajo la clasificación en la que situó a Ciro y diga qué haría escribiéndolo en el espacio que sigue.

Cuando haya terminado este ejercicio, discuta sus respuestas con un facilitador.



EJERCICIO F

En este ejercicio usted evaluará y clasificará la enfermedad de dos niños. Luego describirá en detalle cómo proporcionaría el tratamiento. Suponga que es un trabajador de salud en un centro de salud. Consulte el gráfico de la página 97 y escriba sus respuestas al ejercicio en el espacio proporcionado en esta página.

CASO UNO: Elsa

1. Lea la siguiente información sobre el caso.

Elsa tiene 2 años de edad. Su madre dice que ayer Elsa se puso súbitamente muy enferma. Tenía tos y le goteaba la nariz durante dos días, pero la madre no creía que necesitaba ningún tratamiento. Ayer dejó de jugar, y su madre observó que estaba respirando más rápido que lo normal.

En respuesta a sus preguntas de evaluación, usted se entera por la madre que Elsa ha podido beber agua y comer un poco. Su madre no cree que tiene fiebre, y no hay malaria en la zona.

Cuando usted cuenta la respiración de Elsa encuentra que respira a razón de 36 veces por minuto. Cuando su madre la desviste, usted ve que Elsa no tiene tiraje. Está sibilando y la madre dice que es la primera vez que ha escuchado a Elsa hacer este ruido. No parece estar anormalmente somnolienta. Pesa alrededor de 11 kg y tiene una temperatura axilar de 39,5°C.

2. Enumere todos los signos de enfermedad de Elsa en el espacio que sigue.

3. Anote cómo clasificaría la enfermedad d Elsa escribiendo la clasificación en el espac que sigue. Enumere también los signos qu usó para clasificar la enfermedad.

4. Mire el plan de tratamiento bajo la cl sificación en la que situó a Elsa, y apunt lo que haría en el espacio que sigue.

5. Por cada medicina que Elsa recibirá, in dique la dosis, con cuánta frecuencia la re cibirá cada día, y el número de días que l tomará.

CASO DOS: Toni

1. Lea la siguiente información sobre e caso:

Toni tiene 11 meses de edad y pesa kg. Su madre lo trajo a ver al trabajado de salud hace tres días porque tenía tos se sentía caliente. En aquella oportunida Toni estaba respirando a razón de 36 vece por minuto y no tenía tiraje. Toni n

quería comer, pero sí podía beber. Su temperatura era de 39,1°C y no había malaria en la zona. El trabajador de salud le dio paracetamol y le indicó a la madre que lo volviera a traer si empeoraba o si comenzaba a respirar con dificultad o rápidamente.

La madre volvió a traer a Toni porque cree que está más enfermo y respira con dificultad. En respuesta a sus preguntas, la madre de Toni le dice que ha estado tosiendo desde hace más de una semana. Todavía puede beber. Cuando examina a Toni, encuentra que respira a razón de 62 veces por minuto, no tiene tiraje y su temperatura axilar es de 37,8°C.

2. Enumere todos los signos de la enfermedad de Toni en el espacio que sigue:

3. Anote cómo clasificaría la enfermedad de Toni escribiendo la clasificación en el espacio que sigue. Enumere también los signos que usó para clasificar la enfermedad.

4. Mire el plan de tratamiento bajo la cla sificación en la que situó a Toni, y apunt lo que haría en el espacio que sigue.

5. ¿Por qué razón le dio el trabajador d salud paracetamol a Toni hace 3 días?

6. Usted tiene paracetamol, un remedio se guro para la tos hecho en el centro de salud y tabletas de cotrimoxazol tamaño de adult (de 80 mg) para tratar niños enfermos. ¿Qu medicina le daría a Toni ahora?

¿Cuánta medicina y con cuánta frecuenci deberá recibir Toni?

7. ¿Qué le diría a la madre de Toni sobr cómo tratar a su hijo en la casa? ¿Qué harí usted para ayudarla a tratarlo en su casa Escriba aquí su plan.

Avísele a un facilitador
cuando haya terminado este ejercicio.

APPENDIX D

EDUCACIÓN, COMUNICACIÓN SOCIAL Y TRABAJO COMUNITARIO.

Utilización de Servicios de Salud en IRA.

Lic. Sandra Sáenz de Tejada /
INCAP, Guatemala.

La neumonía continúa siendo una de las causas más importantes de morbilidad y mortalidad infantil en Guatemala. Para contribuir a aumentar el acceso y demanda de los servicios de salud biomédicos que realizó un estudio etnográfico sobre el manejo popular de las infecciones respiratorias en una comunidad mestiza de Guatemala. La investigación versó sobre la perspectiva comunitaria en cuanto a etiología, interpretación de síntomas, clasificación de enfermedades, patrones en la búsqueda de atención y tratamiento. Se encontró que casi todas las familias utilizan una variedad de recursos, entre los que destaca el autocuidado, el puesto de salud local y el hospital regional; los proveedores tradicionales son poco consultados. La utilización de los servicios está asociada a la percepción de gravedad (a su vez relacionada al diagnóstico familiar y por la presencia de síntomas considerados de alarma: fiebre alta, tos y respiración dificultosa), así como al acceso y disponibilidad de recursos.

Adopción del Manejo estandarizado de Casos en el Personal de Salud: Barreras e Incentivos.

Dr. John Elder /
BASICS, Washington, USA.

Los médicos, enfermeras y trabajadores de salud juegan un papel muy importante en la lucha contra la morbi-mortalidad debidas a infecciones respiratorias agudas en niños. A nivel primario, su intervención adecuada con las consecuentes actividades educacionales sobre prevención, reducirá la necesidad de cuidados y tratamientos más complicados.

El presente estudio pretende acercarnos al entendimiento y solucion de los problemas relacionados con la respuesta apropiada del médico a nivel de atención primaria, en los episodios de IRA en niños.

En Guatemala, así como en otras regiones, los médicos a menudo encuentran muchas barreras para el manejo apropiado de casos de IRA; sin embargo, una minoría sí lo aplica adecuadamente.

Se determinarán las diferencias importantes que existen en cuanto a la percepción de estas barreras y la motivación y habilidades necesarias para sobrepasarlas.

Conocimientos, Prácticas de las Madres sobre IRA en Algunos Departamentos de Guatemala.

Dr. Victor Lara /
Clapp & Mayne, Guatemala.

Las acciones de promoción y educación sobre prevención y tratamiento de la IRA en Guatemala, se han venido incrementando sustancialmente desde el inicio del programa de control de IRA en 1972 y son

APPENDIX E

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Estudio de Actitudes y Motivaciones de un grupo de médicos sobre el MEC de IRA

Dr. John Elder

Dr. Oscar Cordón

odología

- 19 entrevistas a profundidad
- 3 grupos focales
- 3 departamentos

- 19 médicos
- 22 médicos
- Zacapa, Huehuetenango, Ciudad Guatemala

odología

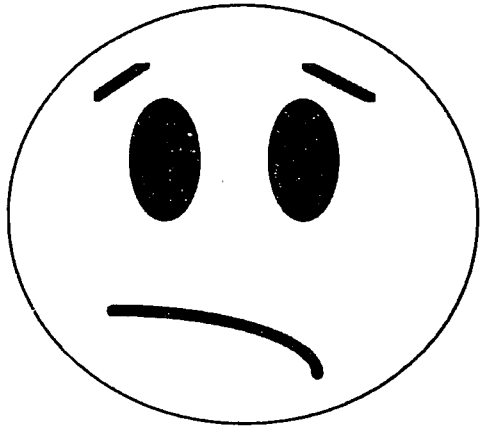
- Los entrevistados fueron clasificados como "CASOS" y "CONTROLES" basados en sus respuestas directas e indirectas, así como en la forma en que ellos hubiesen diagnosticado y tratado un caso de IRA

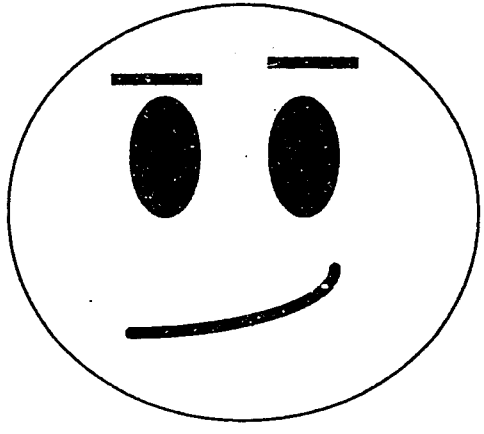
licos Entrevistados

❖ Urbanos	➔ 18
❖ Rurales	➔ 23
❖ Total	➔ 41
❖ Sector Público	➔ 29
❖ Sector Privado	➔ 2
❖ Mixtos	➔ 10
❖ Capacitados con MEC	➔ 14
❖ Sin capacitación	➔ 27
❖ Especialistas	➔ 21
❖ Generales	➔ 20

ASICS

Diseño Epidemiológico
Estudio clásico de Casos y Controles





Casos

Enfermedad +

Controles

Enfermedad -

Exposición

+

-

-

+

idemiología Conductual

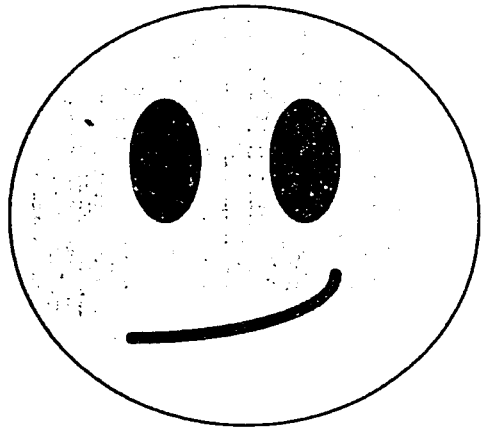
portamiento relacionado a la salud o enfermedad

Casos

+

Controles

-



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-

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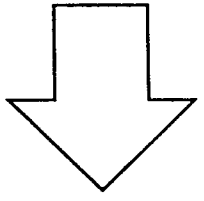
stigación Formativa

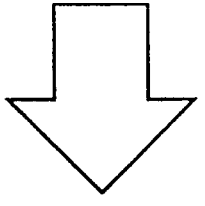
Preguntas Cualitativas sobre
Patrones de Conducta
en relación a

Manejo Estandarizado de Casos
(MEC)
de IRA

Dado el hecho de que algunos médicos si practican el MEC (casos) y otros NO (controles)



Deseamos saber



¿ Qué factores influencian la adopción del MEC y su rechazo, y cómo se podrían modificar posteriormente estos factores?

edibilidad de las fuentes de ormación

- La información técnica actualizada sobre IRA se obtiene principalmente de
  - Publicaciones científicas de OPS / OMS
  - INCAP
  - MSPAS

Métodos de comunicación más eficaces

- Audiovisuales
- Conferencias y/o eventos técnicos especializados en IRA
- Boletín del Colegio de Médicos
- Revista del Colegio de Médicos y Cirujanos
- Revista de la Asociación Pediátrica de Guatemala

[illegible]edores de Información Técnica

- Información proveniente de OPS / OMS
- Información proveniente de MSPAS

dicos Generales

Los médicos generales consideran que

los *PROVEEDORES*

de información de

MAYOR CREDIBILIDAD

son los

médicos *ESPECIALISTAS*

licos Especialistas

La *FUENTE*

de información de

MAYOR CREDIBILIDAD

son los

EXPERTOS DE OPS / OMS

Asimismo tienen credibilidad los

SUB-ESPECIALISTAS

en

NEUMOLOGIA

que presentan casos de sus

prácticas privada

del Visitador Médico y/o Industria Farmaceútica
sos)

- Influencia en los médicos
- Rol en la publicación de materiales
- Influencia en el medicamento a elegir
- Producción de material específico
- Personas claves debido a su relación estrecha y poder de convencimiento con los médicos
- Son más influyentes con los médicos privados

del Visitador Médico y/o Industria Farmaceútica ntroles)

- Muy parcial
- NO informa a los médicos sobre IRA unicamente sobre medicamentos utilizados paralelamente
- Influencian a médicos con pobre formación farmacológica
- Ningun rol con médicos en area rural

ejo Estándar de Casos de IRA (Casos)

- Protocolos se rechazan por desinformación
- Los médicos que siguen los protocolos es porque se han convencido con la práctica
- Protocolos son buenos para nivel comunitario NO para el hospitalario
- Utiles para unificar criterios

ejo Estándar de Casos de IRA (Casos)

- Dejan de ser científicos si siguen una norma tan simple
- Reduce la semiología de un paciente con IRA a dos signos
  - Frecuencia Respiratoria
  - Tiraje subcostal

ejo *Estándar de Casos de IRA (Controles)*

- Individualismo (problema)
- Falta de insumos
- No se les da seguimiento
- Protocolos y normas del MSPAS rechazados por su verticalidad
- Una barrera, cambios constantes

ejo Estándar de Casos de IRA (Controles)

- Convencimientos de médicos con muchos años de práctica
- NO hay confianza en la información del MSPAS
- Médicos especialistas prefieren creer más en su experiencia
- Rechazo a la simplificación
- Material de presentación de normas muy simple

ejo *Estándar de Casos de IRA* (Controles)

- Problema en nuevos esquemas de Tx. cuando no se siguen las jerarquías
- Temor a ser desplazados en cuanto a sus conocimientos

nductas terapeúticas e Incentivos asos)

- Unificar criterios entre las instituciones prestadoras del servicio
- Intercambio de experiencias dentro de los programas de post-grado de residentes
- Establecimiento de premios por investigación
- Información constante a través de las revistas disponibles en el medio

nductas terapeúticas e Incentivos usos)

- Capacitación fuera del área de trabajo
- Cursos por correspondencia
- Reconocimiento y crédito al personal que se capacita

nductas terapeúticas e Incentivos ontroles)

- El mayor incentivo es
  - La actualización constante
  - Adecuada provision de medicamentos
  - Visita de expertos especialistas
- Se estimularía más a los médicos en hospitales si se invitan expertos
- Premios como incentivos no son adecuados, ya que da lugar a favoritismo y corrupción

os Diagnósticos en IRA (Casos)

- No es necesario utilizar Estetoscopio ni Rx.
- La confiabilidad hacia los test de resistencia antibiótica es muy baja
- Credibilidad de los test depende de los laboratorios y casas farmaceúticas
- Test de resistencia se utiliza unicamente en aquellos casos de fallo terapeútico

os Diagnósticos en IRA (Casos)

- Test de resistencia en cuadros de Otitis crónica
- Los test se utilizan cuando el paciente ha sido muy manipulado

Los Diagnósticos en IRA (Controles)

- El estetoscopio y los Rx de Tórax son indispensables

mportamiento de las madres en os de IRA

- Gran influencia de la madre sobre la forma de tratar los casos de IRA
- La relación del médico con las madres varia mucho de un ambiente público a uno privado

mportamiento de las madres en os de IRA en diferentes ambientes

- Impersonal
- Poca calidad
- Muy breve
- Poca profundidad
- Sin énfasis en plan educacional
- Enfocada más a la prescripción
- Menor condicionamiento por el tipo de medicamento

- Demandante la atención
- Mayor calidad
- Mayor interes
- Mayor tiempo
- Mayor responsabilidad
- Ansiedad de los médicos por ser aceptados
- Condiciomiento en el tipo de medicamento

omendaciones

- ✓ Capacitación debe iniciarse con los jefes
- ✓ Continuidad en las capacitaciones
- ✓ Diferente capacitación para cada tipo de médico
- ✓ Capacitación en el servicio
- ✓ Capacitación a través de las Asociaciones Médicas Departamentales