

Consultation report on
“The Project for Child Health in
Department of Quetzaltenango, Guatemala”

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For
Area de Salud, Quetzaltenango, Guatemala
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I. Executive Summary

As a follow-up of last year's bedside clinical training for health staff at the health centers and health posts in five project sites in the Department of Quetzaltenango, Guatemala, bedside clinical skills training and hands-on workshops were provided during my stay between March 10th and 23rd, 2007. The revised NS Chart was also implemented. Six residents in the International Health Track, Department of Family Medicine, UH/Case Medical Center were recruited to cover as many health posts as possible and provide several bedside sessions simultaneously in multiple locations.

Our NS Chart and the Assessment Triangle were widely used in daily practice, and the bedside skills they learned during our training were widely utilized. However, the referral system we developed to connect health posts and the Provincial Hospital in Quetzaltenango was not functioning properly because up to 50% of referred patients did not go to the Hospital. Since the overall goal of this project is to curb U5MR by half in 4 years, it is critical to develop secondary care capability for backing up primary care facilities to treat sick children in timely manner. Therefore, the next step of the project rests on how we can beef up the secondary care facilities to provide better support for the frontline health workers in the health posts.

II. Activities

1. Provided bedside precepting for health staff at the health posts and the health centers in five project districts. The focus of the teaching was primarily on skills in physical examination, interviewing, and triaging sick children.
2. Implemented workshops on highly demanded topics: dermatology, pulmonary diseases, burns and trauma, prenatal care and suture skills.
3. Investigated the validity of the NS Chart, which is a screening tool for referring patients with pneumonia, the number one infant killer in the area, and discussed with the head pediatrician at the Hospital to review the referral system between health posts and the Hospital.
4. Revised the NS Chart by incorporating sections for managing dermatologic conditions.
5. Reviewed the content of teaching material, "Cinco Cuidados Basicos".

III. Observations and problems

1. The majority of the health staff at the health centers and health posts has retained and utilized the knowledge and the skills we taught in our workshops last year.

They have employed assessment triangle to evaluate patients and used the NS Chart to triage patients for urgent referral for diarrhea and respiratory illnesses.

2. As an effort to develop functional referral system in the area by linking health posts and the Provincial Hospital, a standardized referral form was introduced and regular follow-up meetings with the MOH officials and pediatricians were held in the past year. However, it turned out that only up to 50% of referred cases from the health posts did go to the Hospital. The patients' mistrust to the Hospital care due to the negative experiences and reputations seems to have been one of the serious underlying causes. The actual reasons for noncompliance to medical advice should be elucidated by further survey.
3. Many adult illnesses encountered at health posts included somatization syndromes, e.g. chronic low back pain, epigastria pain and headaches. Many non-acute medical conditions were also presented at the health posts. Chronic pain syndrome is closely related to psychological and physical stresses. Considering the fact that the underserved population, who are the target of this project, are under sever chronic poverty, it is questionable whether the current modality of intervention is the most effective way to deal with their complaints. Some kind of community-based interventions for anti-poverty activities and health education, and/or utilization of resources other than giving away quick pain-relief pills would be necessary.
4. The health centers still do not provide any advanced treatment as a backup of the health posts. In other words, there is not much difference in the capacity of medical care between the health posts and the health centers. It also means that there is no health care pyramid functioning in the project area.
5. The NS charting system is in place in all health posts in the project areas. However, in order to the NS system would curtail infant mortality, there are several assumptions.
 - 1) The conditions that take away child life have enough time windows that allow timely intervention to reverse the condition.
 - 2) The user of the health system is compliant to the system (no censure).
 - 3) Existence of reliable secondary and tertiary health care provider.

Among above three assumptions, the latter two are not met in the project sites. The NS charting system, like other similar schemes based on IMCI approach, is a triage tool rather than a diagnostic one. Therefore, the success of the NS system is dependant on the availability of higher care facilities that can provide appropriate support for lower tier of care. Without functioning secondary care (health center) and high censure rate for tertiary care referral, the success of entire system based on the NS system seems dismal.

IV. Issues with the Counterparts

1) Because of the vaccination campaign in Guatemala, it was extremely difficult to even get together with my counterparts, Dr. Diego Manrique and Dr. Juan Carlos Moir. Dr. Moir joined us in our visit to the health posts only a few times. The sustainability of this activity is heavily relies on their ability to schedule field visits during my stay and willingness to take the most of my “technical assistance” by working together. My participation to this project was severely compromised by their absence. In addition, it was quite depressing to see that frequent changes in the leadership of the Ministry of Health had negatively influenced to the motivation of all staff members of the Area de Salud in the Department in Quetzaltenango.

2) The doctors at the health centers are supposed to play a key role for the health system in each project district. In reality, their skills as well as their work ethic have cast a shadow over the quality of health services and the process of earning patients’ trust to the system: they can stay only few hours a day before they catch buses to go back to town. Remote health centers have experienced very high attrition of the doctors.

IV. Recommendation

1. Strengthen the capacity of health centers as a competent referral center for health posts.

Referred patients have numerous difficulties to go to the tertiary care hospital (III-2). It is, therefore, extremely important for the health center to backup health posts to save sick patients triaged by the NS Chart. Under the current circumstances, this triage procedure is simply wasted and patients are only succumbed to illness. If health centers are beefed up, there are several advantages:

- 1) Health centers will function as referral centers for health posts for further treatment of common illnesses and trauma.
- 2) Unlike the Provincial Hospital, the geographical proximity of health centers will make access of care easy for many users.
- 3) The communication between health centers and health posts is easier than between the Hospital and health posts because of the familiarity of personnel in both facilities. The closer communication would enhance the continuity of care for patients.
- 4) The proximity of health center to health posts enables timely administration of necessary treatment and/or stabilization of condition in case patients need further referral.

2. Recruit motivated physicians for health centers.

The major obstacles to strengthen health centers in my observation are as follows:

- 1) Many physicians need further clinical training to better deal with sicker children and trauma cases using advanced medications,

- 2) Many physicians commute to their health centers from the town, subsequently, they are physically present only between 9AM and 3PM at most, and
- 3) Judging from the high attrition rate among the physicians in remote health centers, there is apparent lack of incentives and motivations to work at the health center.

The alternative ways to improve physicians' motivation and provide quality of service are:

- 1) Recruit Cuban physicians who are well-reputed as hard working and not minding to stay in rural areas,
- 2) Intensify collaboration with medical schools and mobilize medical students as alternative workforces to physicians. Yet, medical students require appropriate precepting and mentoring, it is essential to develop plans to provide on-going supervisions to students by the staff of the Area de Salud, and
- 3) Recruit private physicians as a local consultant for the JICA project. The locally recruited physicians would provide supervision to medical students and other health professionals at health centers.

If requested, the Department of Family Medicine, Case Western Reserve University, Cleveland, Ohio, USA, can provide technical support for medical knowledge, skills and supervisions through bed-side teaching and hands-on workshops to the health professionals every 16 weeks between June 2007 and May 2008.

3. Conduct a thorough investigation on the patients who did not go to the Hospital even though they were referred.

From the viewpoint of quality improvement, it is critical to obtain feedback from service users who were not satisfied with the system. The survey results proposed here would serve as a valuable resource to improve services to the needy users.

4. Conduct a study of “ecology of care” to elucidate the nature of health care utilization at the target communities.

As I discussed in my previous consultation report in 2006, there is no data to support the existence of single “health care pyramid” in Guatemala. To find out the nature of health seeking behavior in the project sites will have a huge impact on planning and readjusting the project for the next step. We cannot simply depend on feedback from our patients who use the health posts, health centers and/or the Hospital since we would like to know the true nature of health seeking behavior including non-users'. We definitely need data drawn from the community based on a sound sampling method.