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TECHNICAL REPORT SUMMARY

The Spread of ProCONE: A Case Study from Guatemala

Introduction

Between March 2007 and September 2008, the USAID-funded *Calidad en Salud* Project, implemented by University Research Co. LLC (URC) carried out an initiative to improve the quality of essential obstetric and newborn care services (*Promoción y Cuidados Obstétricos Neonatales Esenciales*, known by its Spanish acronym, ProCONE). Implementation began in 25 health centers in the San Marcos Health Area in the highlands of Western Guatemala, and in 2009 was expanded to an additional 79 health posts and 56 primary care units in San Marcos and in eight other health areas. USAID | *Calidad en Salud* supported these efforts until the project ended in September 2008, when support for ProCONE continued under the USAID Health Care Improvement Project (HCI), also implemented by URC. ProCONE emphasized compliance with norms for prenatal, postnatal, and neonatal care. In addition, counseling, and selected interventions for children under 24 months (growth monitoring, breastfeeding, complementary feeding, micronutrient supplementation, and vaccination) were monitored.

A study was conducted in which data were collected to determine the extent to which the best practices developed during the initial demonstration phase were successfully spread to and adopted by those health facilities participating in the expansion phase. It found that facility staff members in the spread phase were not familiar with the best practices document that resulted from the demonstration phase. Of those changes implemented at the facilities participating in the spread phase, only 13% were identical or similar to changes implemented in the demonstration phase (Hurtado and Ramirez 2012).

The aim of this case study was to gain a deeper understanding of how the process of spreading innovations and “best practices” to other health facilities worked in the context of ProCONE. The specific research questions for this case study included:

1. How did the health facilities included in the spread phase learn about change ideas and best practices?
2. How did the facilities select and adapt the best practices they implemented? Why were adaptations necessary?
3. What perceptions does facility staff have of these changes and of the process of spreading “best practices” tested by other health facilities?

For the purposes of this study, spread is defined as the deliberate diffusion of a practice that has been shown to produce better results than the current practice (Massoud et al. 2010).

Methodology

This study was conducted in one health district in the San Marcos Health Area in the highlands of Western Guatemala. The area was selected purposively as it was a priority area for USAID in the areas of agriculture and economic development through the U.S. Government-funded Feed the Future strategy. The district was also selected considering language because much of the population spoke Spanish in addition to the local Mam language. The district included one permanent care center (CAP),

two health posts, and one minimum care unit. The existing district health center was converted into a *Centro de Atención Permanente (CAP)* in February 2009, increasing the hours of operation and number of staff and enhancing the services provided to include labor and delivery and emergency ambulance services. One of the health posts had four nurses and one Cuban medical doctor on staff. This health post served a larger catchment area than the others and thus was equipped with an ambulance. The other health post and the minimum care unit had two nurses and one nurse on staff, respectively. The medical doctor and the nurse at the minimum care unit were not fixed positions, meaning annual turnover in staff. The minimum care unit was not established by the Ministry of Health, but rather was set up and continues to be maintained by the municipality based on locally recognized needs. It did not have electricity, necessary for storing vaccines.

Qualitative methods were used to collect data. The first author spent a week in San Lorenzo in August 2011, dividing her time between the four facilities included in the study. Semi-structured interviews were conducted with three nurses and the head doctor who participated in the ProCONE program. Themes included challenges in service delivery prior to the start of ProCONE, the process of learning about ProCONE, and how ProCONE spread and functioned. Observation was conducted in each of the participating facilities and during the first day of a two-day training on family planning that was financed by HCI and facilitated by staff from the San Marcos Health Area.

Iterative thematic analysis of the interviews and observations was conducted. Analytic memos were produced at the end of each day of data collection to extract themes and identify areas for further investigation for subsequent days of data collection. All interviews were conducted at the health facilities when the respondent was available. Interviews were conducted in Spanish and were audio-recorded to ensure accurate representation of the words and sentiments of the respondents. Informed consent was obtained from each respondent.

Findings

The spread of ProCONE from the CAP to the health posts and the minimum unit began with the head physician at the CAP. She introduced the strategy to the nurses and was responsible for their training. According to one of the nurses, “the doctor always explains everything to us.” The doctor explained that in early 2009 only the CAP (then a health center) participated in ProCONE. But “after two or three months we got the health posts involved because we were working and the health posts weren’t improving,” she said. The process of involving the other facilities began with conducting a “baseline” assessment, which, among other things, revealed that the facilities were lacking basic equipment to provide quality services. For example, according to one of the nurses, the facilities did not have scales for weighing babies, sphygmomanometers “in a good state”, or sheets. Equipment was moved among the four facilities to ensure that basic needs were met. This exercise served to bring together the staff of the four facilities to form a team.

The meeting and training observed during the fieldwork offered health workers from the entire San Marcos area an opportunity to learn about the ProCONE strategy and changes and practices that were successful in other facilities. In the days leading up to the meeting, the staff from all four facilities in the study area worked together to design a creative presentation of their indicator data. This preparation, as well as the participation in the meeting itself, contributed to the success of the group and the shared learning across facilities.

Two best practices were most frequently mentioned during the interviews – standardization of the patient charts and home visits for pregnant and postpartum women and newborns. By standardizing the clinical data recorded in patient charts, the indicators for improvement could more readily and accurately be measured. All four facilities had time series charts for the indicators hung on the walls of the waiting areas which demonstrated an overall improvement in the indicators. When asked to explain why there were dips in the data in certain months, all participants responded that at times the charts

were not completed even though the service was delivered. An example offered by one nurse: “a child is weighed but it isn’t noted”. One of the challenges in documentation was staff turnover. The nurse in the minimum care unit and the doctor at one of the health posts were on one-year contracts. Thus, every year new staff arrived and needed training in documentation, which was burdensome to the doctor at the CAP and the other nurses. However, the fact that the training continued despite this turnover and the burden it presented indicates a certain level of institutionalization of the practice.

The other best practice—conducting home visits—was also presented to the nurses by the doctor from the CAP. There were no adaptations to this intervention based on individual facility needs. A nurse at one of the health posts reflected on the challenge home visits presented because her catchment area was very large and mountainous. Fuel for a motorbike was not provided, so home visits were limited to areas within walking distance of either the facility or the nurses’ homes.

All four health workers interviewed for this case study spoke positively about the ProCONE strategy. The doctor at the CAP described the services prior to the arrival of ProCONE as “not being integrated” and for this reason “we did not have quality care”. Standardizing clinical records and examining facility level data revealed that “we had many lost opportunities.”

An essential component for the functionality of the group was the communication between facility staff. The nurses from the health posts and the minimum care unit frequently visited the CAP and had monthly meetings to discuss facility data. Additionally, the doctor from the CAP would conduct visits to each of the facilities to supervise service delivery and build capacity for accurate chart completion.

Conclusions

The findings from this case study indicate that some of the proven best practices for effective implementation of ProCONE were successfully spread from the CAP to the lower level facilities and that there was success in implementing selected best practices. These practices were disseminated from the doctor at the CAP to nurses at other facilities. There was no defined process of collecting and analyzing data, identifying gaps, and implementing changes. It also appeared that there was limited understanding of how to analyze and interpret data to make decisions on organization of health services or other relevant improvements. Despite this study’s limitations, including the short period of data collection, limited scope, and the absence of data on coverage of obstetrical and newborn services, it does demonstrate that qualitative exploration into what occurs within a health facility offers a useful understanding of the process of sharing and implementing best practices than quantitative indicators alone. Additional studies of practices at the service delivery level would enhance understanding of the process of spreading best practices to improve the quality of care.

References

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