

Letter

A process of change in first-line health services in Chad

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Training in the field of community participation, district planning and immunization programme management exists at national and regional level in Chad. Many strategies for improving specific activities have been tried and training is sometimes decentralized at district level.¹ Changes introduced following such training involve many people. Nonetheless, all these inputs seem to have had little impact on health service organization and quality of care at the health centre level.²

We would like to discuss the problem of the poor quality of services in an urban health centre in Chad. The urban health centre of Pala's town (30 000 inhabitants) is located in the district of Pala, province of Mayo-Kebbi, south of N'Djamena. This health centre is located in the immediate surrounding of the reference hospital. It is common to see activities such as immunization or antenatal care exclusively provided for the whole urban area by the staff of the hospital, in the walls of the hospital. This means, in practice, a total lack of interest from the health centre team for those activities, a lot of confusion regarding the responsibilities of each facility, and a lack of knowledge of their catchment area and their target populations. Observation showed other problems at first-line health service level: a lack of knowledge of the activities carried out by the other members of the health team; a lack of standardized instructions, and evidence that those in existence are not known by the health workers; missed opportunities to immunize children, with the consequence of repetitive epidemic situations over the past years; and an intra-institutional problem of accessibility to the pharmacy (with a direct compliance problem).

In a context where it is difficult to have anything but a relatively quick and structured support system for improving the general quality of care in a district or health centre, it is important to think about simple and feasible alternatives. The choice of one specific problem in a situation of multiple inter-related problems was needed as a starting point for a process of discussion and communication: the reorganization of the flow of patients was seen as a common problem involving each member of the team. The changes proposed were based on the following hypothesis: 'the reorganization of the flow of patients at the level of the health centre could be a good

opportunity for reinforcing the capacity of the staff to work as a team'.

To achieve the different steps of this process, several meetings were held with the whole health centre team (head nurse, second nurse, two midwives, social assistant, three pharmacists and five auxiliaries) and the district medical officer. As the changes have been implemented, meetings have been organized in more restricted groups on several occasions. The initial meetings were most important for establishing a relationship of mutual respect and confidence between the supervisor and the team, and between the members of the team.

Solutions were discussed and changes have been implemented (over a time period of approximately 6 months) including the following:

- changes necessary for a more efficient use of the health centre infrastructure were very quickly implemented by the team (activities of immunization and antenatal care);
- the midwife insisted on having outreach activities for antenatal care;
- the head nurse decided to join the outreach clinics to try to integrate family planning with antenatal and under-five clinics;
- the head nurse delegated to the social assistant responsibility for the screening of under-five children on a continuous basis from the patients coming for consultation;
- a waiting area for mothers and children was negotiated with the health committee, which agreed to finance most of its construction;
- the health centre care for malnourished and at-risk children has worked out a nutritional programme based on Soya (thanks to a local association for the promotion of Soya in Pala).

As this case presentation has shown, circumstances were favourable for implementing changes involving the actors of the first-line health services. The objective was also to promote creativity and dynamism in the team. In addition, the health centre's head nurse had the knowledge needed to understand the general objective of improving quality of care,

and was competent enough to ensure the dynamics of change. Therefore, circumstances were favourable for developing a local process of quality assurance.³ These conditions may be difficult to meet in other health facilities in Chad or other countries.

At first, it may seem that practitioners do not want to be involved in changes occurring in their local health care system. Many conditions (especially at district level) have to be brought together to give the health staff a proper understanding of what their health service is all about. The better understood it becomes, the more they are willing to participate in the planning and running of the services. Improving quality of care at the level of the district by favouring a local process of auto-evaluation and quality management may provide staff with the opportunity for a dynamic understanding of their facility. Improving quality of care by using such a process would no longer be an individual health staff problem or an isolated strategy. The necessity for specific changes would have to be seen through a more general or global view of the functioning and understanding of interaction between all the actors involved.⁴ This is an important factor in developing the general effectiveness of health services

through optimizing the potential of each actor involved as part of the team. This is potentially a more effective strategy than seeking to maximize the inputs and outcomes of a single health worker. This change was identified as an opportunity taken to reinforce the capacity building of the health team. Emphasis is put on the importance of having a common 'felt problem' for introducing concepts of quality of care.

References

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