

407: THE QUALITY IMPROVEMENT PROCESS IN THE NICARAGUAN PUBLIC HEALTH SYSTEM, A CASE STUDY

Authors:

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Objective:

Set up of a continuous self-sustainable process of quality improvement in the first level of health care with a user-friendly management tool.

Methods:

The process of health care improvement at the primary level in Nicaragua started in 2000 with the development of a training tool on quality management for health center staff. The training tool is a praxis-oriented manual following the philosophy of learning by doing. The methodology is based on the following principles: personnel's change of attitude as a prerequisite for any improvement; change understood, too, as teamwork within and among hierarchies; change is possible only with the commitment of the leadership; all personnel has to be involved in the change process; the process has to become continuous and self-sustainable, without external assistance. Facilitators coach Health Centers for several weeks in the beginning.

As a basic organizational requirement for this process, a Quality Coordination Group has to be created in each unit to continuously promote the process of quality management, while Quality Circles are formed to solve specific problems prioritized by the concerned health personnel.

The process starts with the recognition of the, often negative image of the health unit by clients and staff (satisfaction assessments are organized for both groups); it continues with the formulation of a slogan by the staff on how they want their work to be seen ("Together with the community we improve health"), then a commitment signed by the director of the health unit to promote change, the critical issue in the process. It continues with the involvement of all health personnel and the community into the process through flyers, parties, assemblies. Only afterwards the Quality Coordination Group is formed, a specific problem in a priority program is identified and has to be solved by the quality circle within 3 months, then another problem has to be identified, another quality circle formed etc. The Quality Coordination Group monitors the process and reports to the unit's director.

Results:

One of the four Health Centers, where this approach was implemented, dropped out because of leadership problems within its executive board. The other three continued with success: one solved the problem of insufficient education material by elaborating flipcharts. Another improved its patient registry with emphasis on prenatal care, leading to a significantly shorter waiting time for pregnant women. The third Center improved its system of following up high-risk pregnancies. It claims, supported by its statistics, that this has led to fewer cases of maternal deaths (in 2000: 5 cases and in 2001: 1 case) and fetal deaths (in 2000: 31 cases, in 2001: 22 cases).

The implementation of this approach has started in another 20 health centers and 2 of their reference units. After its thorough review, the Nicaraguan government has decided to replicate it nationwide.

Conclusions:

Although the implementation of the process has been rather short (about one year), the results indicate improved management of the health centers. We expect that in about three years there will be statistically significant evidence, because of the larger number of cases involved, not only concerning indicators of health services, but on impact indicators like the reduction of maternal mortality. We are setting up a monitoring and evaluation system for this purpose.

The results up to now indicate that this easy-to-apply approach involves only small costs and leads to a continuous, sustainable process of quality improvement in primary health care.