Strengthening Community-based Family Planning Systems through Collaborative Improvement in Busia District, Uganda

MARCH 2017

Busia District's contraceptive prevalence rate has increased from 16%[1] to more than 30% since the CBFP improvement effort began, the District Health Office reports.

At all three pilot CBFP improvement sites, 70% of clients return for follow-up visits — a return rate much higher than the national average of 53% percent.

CHANGE PACKAGE TO IMPROVE CBFP

- **To ensure adequate counseling:** Use the FP counseling book as a reminder.
- **To improve FP counseling:** Midwife and VHTs hold QI sessions that include observation of and feedback on counseling.
- **To increase male involvement:** Use two-minute FP "elevator speech," a basic script developed by collaborative representatives for the VHTs' use.
- **To improve retention on FP:** Engage expert clients to dispel myths. Conduct home visits to remind clients about follow-up visits and (with a client's permission) talk to partners.

QUALITY IMPROVEMENT BRIEF - ISSUE 2

Introduction

Uganda's first learning site for community-based family planning (CBFP) — established in Busia District by the Advancing Partners and Communities (APC) project in partnership with the Ministry of Health (MOH) — aims to increase uptake and sustained use of family planning services among women of reproductive age.

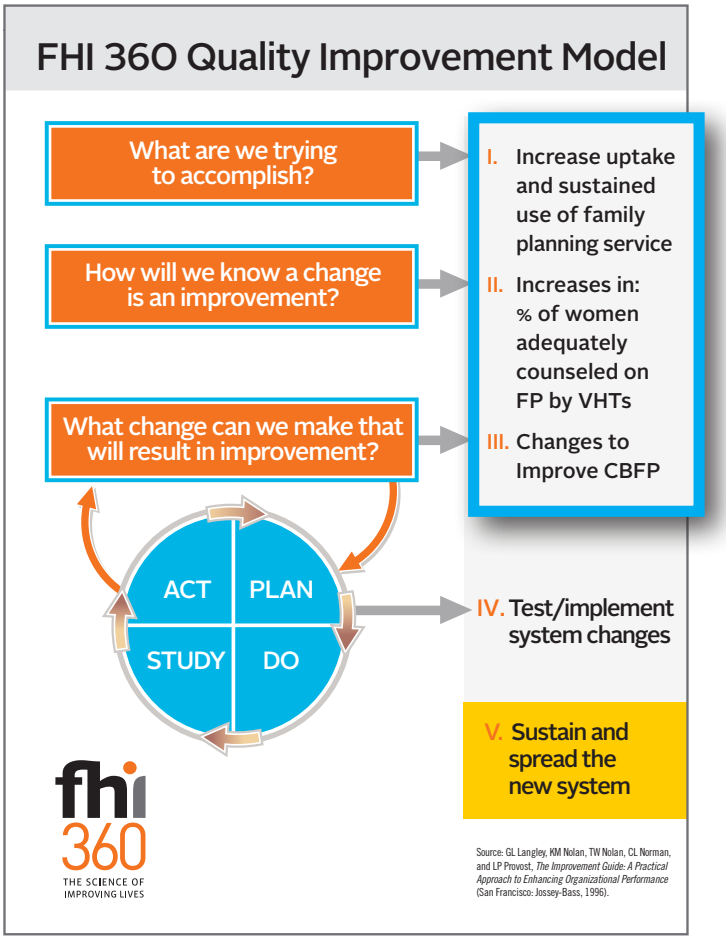
In this second issue of the APC Quality Improvement Brief, we describe the progress to date in systematic efforts to improve the quality of CBFP in Busia District and plans to scale up these efforts in two other districts in Uganda.

The Improvement Effort

In Busia, 14 midwives and 118 community health workers known as village health team members (VHTs), in-charges and midwives from seven health centers, and a principal nursing officer work together to implement a quality improvement (QI) effort based on the Collaborative Improvement Model.[2] With APC technical assistance, the nursing officer serves as a district-level QI mentor, and each health center catchment area has a QI team consisting of VHTs, who function as QI champions, midwives, who coach the VHTs, and clients, who participate in learning sessions.

VHTs, midwives, a QI mentor, an APC project member, and HC in-charges discuss ideas for improving CBFP.

Midwives conduct monthly facility-based QI coaching and FP mentoring sessions where they guide the VHTs in using improvement principles and processes to identify and implement changes to improve service delivery. The midwives also mentor VHTs through either direct observation of FP counselling and service delivery or role plays. Progress reviews between midwives and VHTs provide additional opportunities to educate and support the VHTs in problem solving. The improvements developed during the sessions are tested through the Plan-Do-Study-Act (PDSA) Model (see box on following page) and become the basis for a validated package of changes that have proved effective in the local context (see blue box to the left).



Ahievements and Lessons from Busia District

- Frequent QI coaching sessions in the three pilot HCs (14 conducted from June 2015 to December 2016) involving stakeholders at all levels strengthened common understanding, provided practical feedback, and facilitated the success of QI processes.

- By December 2015, all three sites were monitoring QI measures and plotting them on run charts (see graphs on page 3). The practice of self-monitoring and interpretation of graphs in team meetings has increased interest in QI and innovation among the VHTs.

- A change package (see blue box on page 1) that is continuously updated guides new VHTs and the scale-up of QI. Because the changes are simplified and localized, there is more ownership of them among the QI teams and greater sustainability of community-based QI.

- QI coaching sessions have led to greater involvement in FP issues among midwives and in-charges compared to that of other districts in Uganda, report those who provide supportive supervision. VHT interaction with and support for clients have increased, and critical support to VHTs' has improved among HC-based QI mentors (midwives).

- The improvement effort started with three HCs and has now been scaled-up to four new HCs, covering the entire district. The Busia CBFP learning site teams have played an active role in the scale-up of the collaborative QI effort in Oyam District, and a delegation from Oyam District participated in the November 2016 learning session in Busia.

- The APC QI team and the Busia District officials gave three presentations at the National Quality Improvement Conference in Kampala in August 2016.

What VHTs in Busia say about being part of CBFP Learning Center of Excellence:

"Ordinary people can do extraordinary things."

"Complicated and advanced for me, but I understood"

Results

An analysis of the QI data collected by the VHTs in Busia District from June 2015 to December 2016 shows progress in the three pilot sites (Buteba, Buhehe, and Bulumbi) and the four sites in which the QI initiative has been scaled up (Lunyo, Lumino, Busitema, and Mbehenyi).

OBJECTIVE 1: Ensure all female clients (new and returning, 15-49 years old) receive adequate counseling from VHTs on the side effects of FP methods, including LARCs.

Findings (see graph 1): By December 2016, VHTs in all the pilot sites reported following all the steps in the FP counseling checklist with 90% of clients, and the scale-up sites reported doing so with 60% to 80% of clients. In the scale-up sites, VHTs began to record providing adequate counseling in February 2016 after they started using a counseling flip book as a job aid. The VHTs also increased the time spent counseling clients, which helped them realize that whether and how to disclose FP use to partners should be incorporated into counseling sessions to help women gain the support of their partners for sustained use of FP methods.

OBJECTIVE 2: Increase the percentage of female clients counseled with their partners by VHTs.

Findings (see graph 2): Reaching FP clients and their partners as couples is the most challenging objective for the VHTs. Some VHTs report that they use follow-up visits to clients' homes (with prior permission from the FP client) to counsel women with their husbands and record the couples counseling in the VHT registers. VHTs also counsel couples when partners accompany women on hygiene, immunization, and antenatal care days. The VHTs have found that reaching out to younger couples is easier; efforts to counsel this group explain, in part, the slight improvement in the percentage of couples reached. VHTs do not talk to a partner if the woman does not want her partner to know she uses contraception.

OBJECTIVE 3: Increase the number of male clients receiving FP information and counseling during interactions with VHT.

Findings (see graph 3): Various changes tested by VHTs in both the pilot and scale-up sites appear to have contributed to an increase in the number of men reached per month, which rose from 50 to over 300 within a year. VHTs learned that compared to older men, young men were more willing to support their wives' use of FP methods, in several cases, so that they could go back to school.To reach these men, VHTs began giving FP "elevator speeches" during village savings and loan association (VSLA) meetings, men's drinking group (MALWA) meetings, gatherings of church congregations, and even through meetings convened by the local counsel chairperson. Recently APC conducted informal small group discussions in all seven sites, which also helped involve more men. VHTs from the seven HCs were able to counsel a total of 1,793 males, or an average of 149 men per month, in 2016.

> FP Elevator Speech (excerpt)
>
> "I and my wife have been using FP for the last 9 years and in between we have had two children....We need to have families that we can look after."

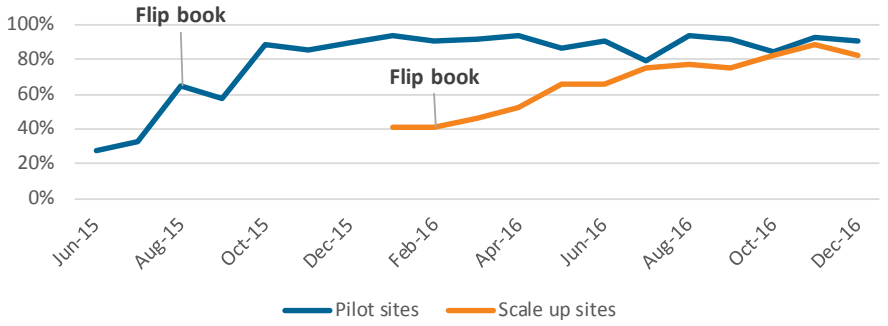
OBJECTIVE 4: Increase the number of female clients who return to the VHTs for FP services within the appropriate time.

Findings (see graph 4): The return rate in both pilot and scale-up sites has reached 60% to 70%. The VHTs proactively reminded women about their next appointments through phone calls, appointment cards, and home visits.

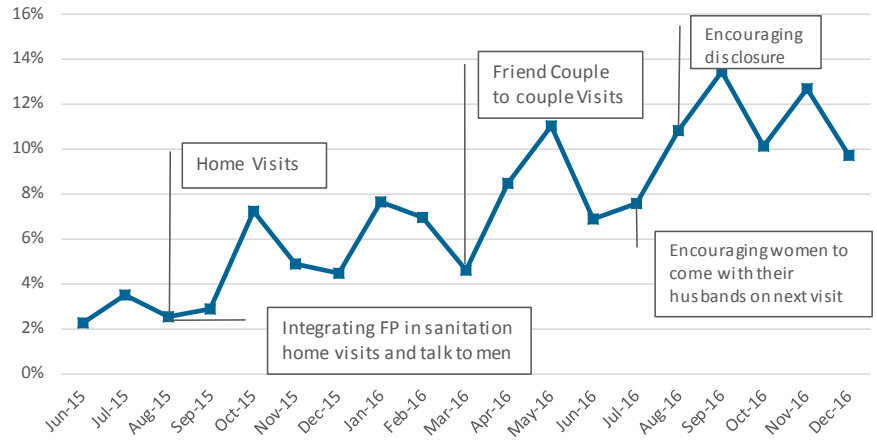
Challenges

The CBFP QI effort faces a number of challenges. The VHTs usually counsel clients on the side effects of only the short-term methods they provide (pills and injectables) and refer the clients to midwives for counseling on

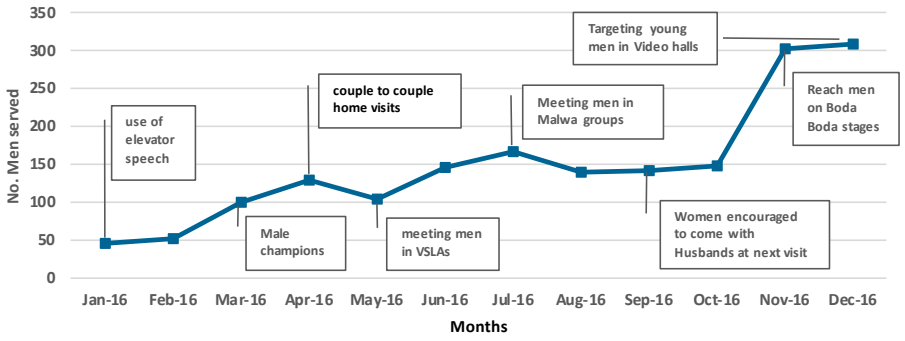
GRAPHI 1 - PERCENTAGE OF CLIENTS ADEQUATELY COUNSELED FOR FP BY VHT (PILOT AND SCALE-UP SITES)



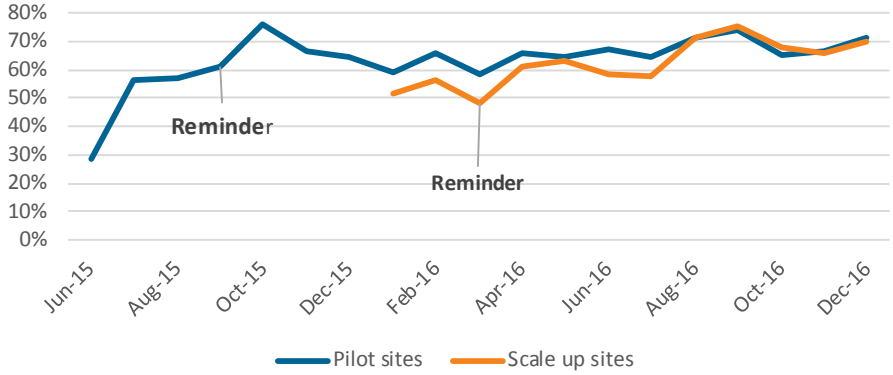
GRAPHIC 2 - PERCENTAGE OF FEMALE CLIENTS COUNSELED AS COUPLES WITH THEIR HUSBAND (PILOT AND SCALE-UP SITES)



GRAPHIC 3 - NUMBER OF MEN REACHED WITH FP SERVICES AFTER SCALE-UP IN BUSIA DISTRICT (PILOT AND SCALE-UP SITES)



GRAPHIC 4 - CLIENTS' RETURN RATE (PILOT AND SCALE-UP SITES)



LARCs. According to a root-cause analysis and small group discussions, some women discontinue method use due to side effects.

Despite the VHTs' efforts, few men accompany their female partners for FP counseling. Due to negative cultural norms, religious opposition to FP, and numerous misconceptions about FP methods, many men decline such counseling. In addition, men often do not disclose to a VHT or other provider that they are in a polygonous relationship. According to the Uganda Demographic and Health Survey 2011, 25% of married women in Uganda are in a polygynous union.[3]

Some VHTs did not proactively check whether women returned in time to replenish their chosen methods. Such timely follow-up is essential to helping clients manage problems or side effects and/or referring them to an HC for medical attention and additional counseling. Some women do not return because they do not disclose the use of a contraceptive to their partner and are unable to continue in secret or because they have been influenced by misconceptions about FP expressed by peers or family members.

Improvements to Test

Participants in the November 2016 learning session identified and developed new ideas for meeting the CBFP objectives. These ideas include: encouraging women to disclose FP use to their husbands; scaling up the interventions shown in Graph 3 to all sites to increase male engagement; and establishing VHT "talking homes," where FP posters and information are on display and there is private space where clients can receive one-on-one counseling without interruption.

The Way Forward

Community health worker provision of FP is recognized by USAID as a High Impact Practice for FP Service Delivery,[4] and CBFP directly contributes to addressing the goal of universal access to reproductive health, including FP, under the Sustainable Development Goals (SDGs).[5] The CBFP improvement effort — which has been scaled up to four additional HC catchment areas in Busia District and has begun in Oyam — is helping Uganda make progress toward reaching SDG 3 and the FP2020 goals. This work will be extended to Kamwenge District in March 2017. The APC project is conducting a process evaluation to understand the factors that support improvement, the features of the effort that might be transferrable to other settings, and the indirect effects of the collaborative effort on health systems in Busia District. This information will be valuable for CBFP improvement efforts and also will enrich and guide the FP QI initiatives being implemented under the stewardship of the Ugandan MOH Quality Assurance Department (QAD).

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