

Strengthening Community-based Family Planning Systems through Collaborative Improvement in Uganda: Lessons and Results

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Quotes from improvement team members at new sites

"I like this idea of being a collaborative, because I have got new ideas."

"Everything is possible through teamwork."

"I have learned that Kayunga and Kamwenge can also reach where Oyam and Busia teams are now."

QUALITY IMPROVEMENT BRIEF - ISSUE 3

Introduction

Since 2015, the Advancing Partners and Communities (APC) project has worked in partnership with the Ugandan Ministry of Health (MOH) to improve the quality of and access to community-based family planning (CBFP) services. Using the QI and collaborative models (see Box 1 and Figure 1), FHI 360 is implementing an improvement collaborative under APC in four districts in Uganda: Busia, Oyam, Kamwenge, and Kayunga. In this third issue of the APC Quality Improvement Brief, we describe engaging clients as partners through experience-based co-design, share lessons learned from scale-up, and report on the latest results of the quality improvement (QI) efforts in Busia and Oyam districts.

Clients as Partners: Experience-Based Co-Design

Experience-Based Co-Design (EBCD), developed in the United Kingdom, unites narrative-based research and service design methods to improve patient and staff experiences with health care.¹ Used in more than six countries, the EBCD approach has led to improvements in patients' experiences as well as transformations in health care workforce culture, values, and behaviors.

EBCD uses a participatory approach to fully engage clients in improving or redesigning services. It enables clients to tell the stories of their experiences with health services, often revealing unexpected areas for improvement.



A community health worker shares ideas for improving health care services with his peers in northern Uganda's Oyam District. Photo by Christine Kim/FHI 360

During the APC's most recent learning session in Oyam District in June 2017, we successfully applied the EBCD approach. Based on staff recommendations, we identified clients who were willing to share their experiences and represented the diversity of clients

BOX 1

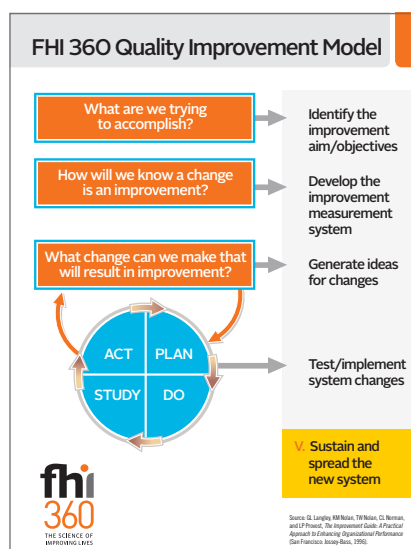
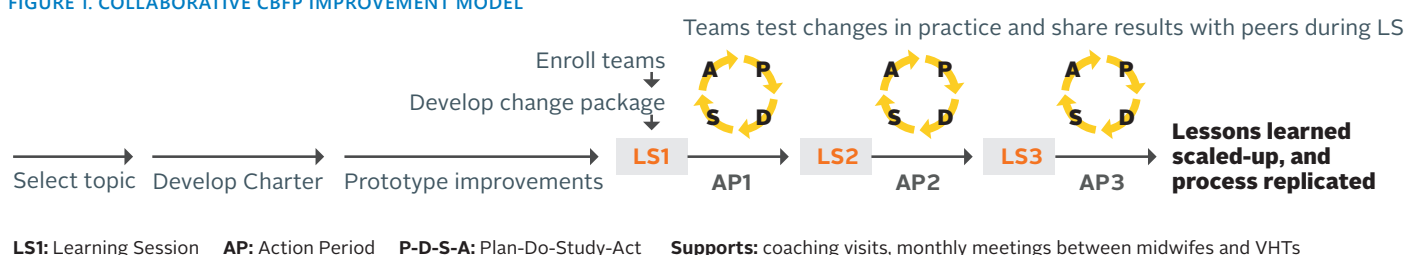


FIGURE 1. COLLABORATIVE CBFP IMPROVEMENT MODEL





Client from Oyam District provides ideas for improving services. Photo by Christine Kim/FHI 360

VHTs serve (youth, single, married, male, and female). We then followed these key EBCD steps: 1) interviewed the clients to gain a better understanding of the care experience; 2) filmed the interviews to reference them later; 3) identified, through dialogue, negative and positive experiences, or touch points, along clients' care journeys and wrote them down; 4) mapped the touch points (with clients' verification) along a negative-to-positive spectrum, which is called an "emotional map"; 5) gave clients, VHTs, and midwives the opportunity to discuss the map and design improvements to services. Examples of ideas for changes that emerged during this process are shown in Box 2.

Our field test of EBCD confirmed that it is possible to not only gain insight into clients' expectations, preferences, and needs, but also involve them in service design and improvement. "Discussion was free and fair," said one client, adding that as a result he felt comfortable sharing the details of his family planning experience and discussing it openly with providers.

Listening to clients' stories helps us understand how our services fit in the context of their everyday lives, beliefs, and

BOX 2. IMPROVEMENT IDEAS FROM THE EBCD SESSION

AIM	CO-DESIGN IDEAS
To involve more men in FP	<ul style="list-style-type: none"> Involve husbands in return visits to VHTs Seek out the fathers of newborns or husbands of pregnant women to talk to them about FP
To reach more couples with FP counseling	<ul style="list-style-type: none"> Have a couple using FP pay home visits to a couple not using FP Schedule more home visits mid-morning (10–11 am) to avoid missed appointments Use the job aids, which have visuals, for counseling during the home visits

interactions. For example, one client said, "I am a better neighbor, because I can take care of my kids better since I started spacing births." The EBCD process also helped the VHTs and midwives appreciate clients' emotions. "I know now what clients truly feel," a midwife said.

The edited videos of clients sharing their experiences can be used in future learning sessions to encourage providers to consider their clients' perspectives while also building empathy for clients among service providers. We will continue to explore the use of this powerful method to engage clients in the improvement journey.

Lessons Learned from Scale-up

Since the July 2015 launch, in Busia with the CBFP Center of Excellence, the QI pilot has been scaled up from three sites in one district to 26 sites in four districts. The scale-up followed FHI 360's collaborative improvement model for management (see page one).

Proper planning and execution are essential for successful scale-up. We managed scale-up as a peer-driven process: champions among midwives and VHTs from the pilot sites played key roles in spreading the process to new sites. The improvement collaborative was launched in June 2015 in Busia District at three sites, or health centers. It was scaled up in Oyam District in October 2016 and in Kamwenge and Kayunga in June 2017. This section describes lessons learned from scale-up.

- Lesson 1: Invest sufficient time in the pilot site to identify what works.** Spend at least six to twelve months with the teams at the initial pilot site to build their capacity in QI and curate the most effective changes. This longer period for start-up allowed for the district and central level MOH officials to be engaged and supportive. They were impressed with the results in Busia, marveling at how well the VHTs applied the Plan-Do-Study-Act (PDSA) model.
- Lesson 2. Set up a clear self-measurement system from the beginning.** Before you start testing changes, develop a set of indicators and targets to measure progress and include them in the QI Charter. Test the indicators and the data collection process with the teams. Continuously monitor data collection and interpretation. "We look at our run chart to see the indicators — whether we have dropped or increased," a Busia VHT explained. "If we have dropped, we look at our change ideas and modify them."
- Lesson 3. Adapt tools and approaches for scale-up.** When we expanded from Busia to Oyam, we adapted the technical content of the improvement work rather than reinventing it. That content included the charter, the change package, progress measures, and processes such as team meetings. Adapting the existing content reduced the time and the level of effort required for scale-up.

- Lesson 4. Continuously look for champions and build their coaching capacity.** Peer-to-peer transfer of experience accelerates adoption. Look for QI champions — people who are interested in improving, measuring, and sharing their work. QI champions serve as change agents for their own sites and for scale-up. A midwife from Oyam described how she learned from a counterpart from Busia as follows: “From Busia I learned that the other midwife was having monthly meetings, and another thing was, she was doing...mentoring. Now I always sit down with them at the end of each week, and I mentor.” Bring representatives of pilot and scale-up sites together through learning sessions and exchange visits. Exchange visits give new sites the opportunity to learn from peers who have successfully implemented the program.
- Lesson 5. Ensure sustainability by engaging health system leaders throughout the process.** Involve the

district QI focal person in facilitating coaching sessions and apply an educative, system-wide approach for community health workers/VHTs, midwives, and district-level supervisors. Keep national leaders in QI informed about the progress of the collaborative effort to seek their buy-in. Early in the project, develop a sustainability plan with the district to maintain improvement gains.

- Lesson 6. Adopt both client- and community-centered approaches for successful implementation.** It is vital that clients’ voices are heard at all levels of the CBFP service system. We learned that the improvement effort must be designed and implemented in both client- and community-centered ways. Involving clients in the baseline assessment and each learning session and using EBCD helped the collaborative identify appropriate changes that could improve CBFP services (Box 2).

Results

The following results are based on an analysis of the improvement collaborative in a pilot site (Busia) and a scale-up site (Oyam), including the implemented changes that contributed to the results. We do not report on results from Kamwenge and Kayunga, because the QI process started later in those districts and we do not have sufficient data to draw conclusions yet.

Figures 2 and 3 present data on key service delivery objectives tracked by the collaborative: client retention and male engagement through couples counseling. The centerline shown in these graphs, which represents the median of each dataset before any changes were introduced, allows us to understand objectively whether the changes that were tested led to sustainable improvements.² We can see in both cases that Oyam, the scale-up district, quickly reached and surpassed the pilot district. This is common in QI collaboratives, because scale-up districts have the advantage of applying changes that have proved successful in pilot districts.

FIGURE 2. PERCENTAGE OF FP CLIENTS RETURNING TO A VHT ON TIME

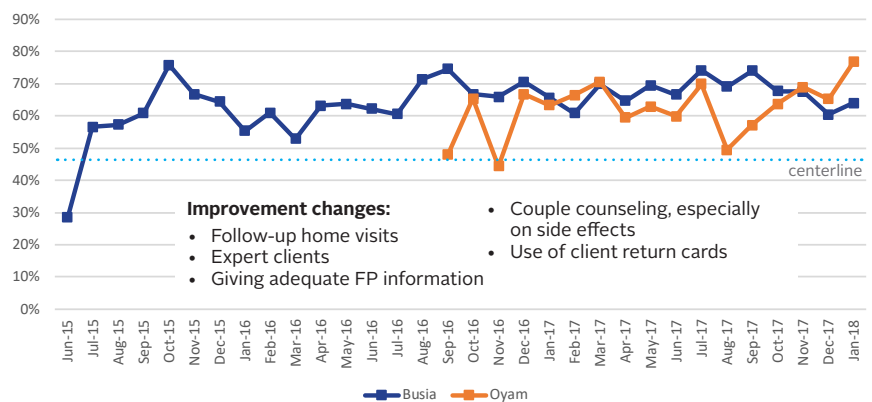
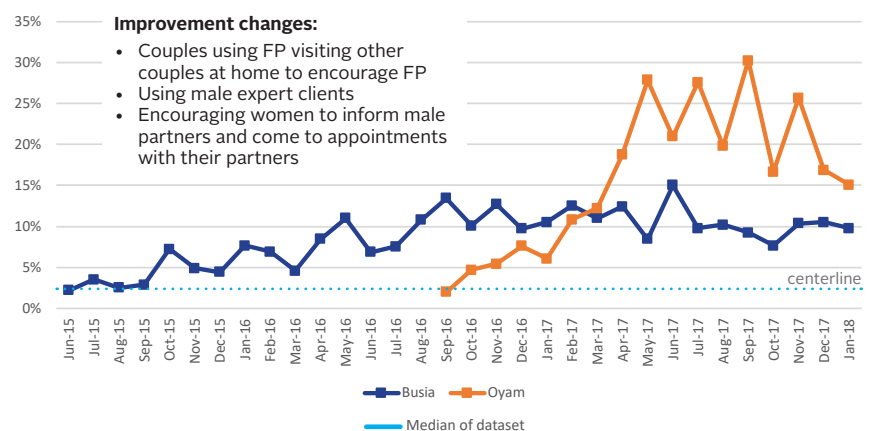


FIGURE 3. PERCENTAGE OF FEMALE CLIENTS COUNSELED WITH PARTNERS BY VHTS



² Perla R, Provost L, Murray S. The run chart: a simple analytical tool for learning from variation in healthcare processes. *BMJ Qual Saf* 2011;20(1):46-51. doi: 10.1136/bmjqs.2009.037895; Perla RJ, Provost LP, Murray SK. Sampling considerations for health care improvement. *Qual Manag Health Care* 2013;22(1): 36-47 doi: 10.1097/QMH.0b013e31827deadb.

Objective: To increase the percentage of female clients who return to the VHTs for FP services within the appropriate time. The primary outcome for the CBFP improvement collaborative, which is the percentage of clients returning on time to a VHT for resupply of FP methods, was low at baseline in both the pilot and scale-up catchment areas. The shift³ shown in Figure 2 suggest that a bundle of simple interventions tested by the QI teams have proven successful. In all sites, client retention has increased to over 60%.

Objective: To increase the percentage of female clients counseled with their partners by VHTs. Low male involvement remains a barrier to the uptake and continuation of FP services. Partner communication can improve FP use and continuation. In Uganda men are often unsupportive of a partner's use of contraception. In Busia and Oyam, many women reported utilizing FP without the knowledge of their partners, which increases the barriers to receiving proper counseling and resupply of their preferred methods. The CBFP QI teams developed change ideas to engage men in FP and improve joint decision-making on FP by couples. Figure 3 shows another shift where the percentage of women who receive counseling with their partners has risen.

We observed similar positive trends for other improvement objectives, including the percentage of clients adequately counseled by VHTs on side effects and the number of male clients receiving FP information and counseling during interactions with a VHT.

The Way Forward

It is important to ensure that the improvement efforts continue even after the project ends. Therefore, each district developed a sustainability plan. Continued improvement efforts in some of the districts will be supported by other USAID bi-lateral projects. During the next phase, APC Uganda will apply the improvement model to new but related problems: large family size and teenage pregnancies in new districts.

APC plans to adapt EBCD to address rapid repeat pregnancies (RRP) among adolescents and women of low parity. This approach will be tested at the facility level with the support of midwives who will provide FP services as part of postnatal care for RRP clients. Through storytelling and in-depth interaction, health workers and clients will explore and address client fears and social factors, as well as identify opportunities created by the midwives.

Applying the proven best practices from the improvement collaborative could enhance the quality and reach of other CBFP programs in Uganda and elsewhere in the Sub-Saharan Africa. APC has proposed assisting the Ugandan Ministry of Health in developing a simple CBFP QI guide to support the scale-up and sustainability of quality CBFP services countrywide.



JSI Research & Training Institute, Inc.



Advancing Partners & Communities

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For previous versions of the QI briefs, please follow these links:

- https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/uganda_qi_brief_final_508.pdf
- https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/8_5x11_uganda_qi_brief_2_v1_508.pdf

³ Shift on a run chart is six or more consecutive points either all above or all below the centerline (median)