

Applying a Quality Improvement Model to Strengthen Community-based Family Planning Services in Busia District, Uganda

FEBRUARY 2016

Uganda has fewer than one doctor per 10,000 clients,¹ and more than 85% of Ugandans live in rural areas.² Ugandan women have, on average, about six children. The country's contraceptive prevalence rate (CPR) is 28.7, and 21% of women ages 15 to 49 have an unmet need for family planning. The highest unmet need is among women in the lowest income group,³ which is the population CBFP programs are reaching.



Coaching session with QI team and clients onsite.

QUALITY IMPROVEMENT BRIEF - ISSUE 1

Introduction

Advancing Partners and Communities (APC) works with the Ministry of Health (MOH) in Uganda to increase access to family planning (FP) in 16 districts through community health workers known as village health team members (VHTs). APC is also strengthening support systems at the district and national levels to advance community-based family planning (CBFP) through a Center of Excellence (COE) in Busia District.

This COE is a service delivery network made up of VHTs trained in CBFP, the health staff of level III health centers (HCs)^a and CBFP clients. Its goal is to create a catchment area within a district health system that has a high-functioning CBFP program with VHTs as core providers of family planning services (see Box 1). The COE functions as a learning site, testing and demonstrating best practices in CBFP (including VHT provision of injectables) that can guide the scale-up of high-quality CBFP services in Busia District and throughout Uganda.

To achieve its goal, the COE is using a collaborative quality improvement (QI) approach at the community level. Several QI projects have been implemented in Uganda to address maternal and newborn care and immunization services.^{4,5} However, to date none of these initiatives has included community-based service delivery. This brief describes the work that Busia District stakeholders have initiated with technical assistance from APC to improve the quality of and access to CBFP services.

Analysis of the Problem

In February 2015 APC, implemented by FHI 360 in Uganda, conducted a collaborative site assessment for CBFP programs with the MOH in the three pilot sites, Bulumbi, Buhehe and Buteba. The assessment identified areas for service delivery improvement, which were quantified by the QI monitoring that started in June 2015:

- Inadequate counseling of clients by VHTs, especially on the possible side effects of long acting and reversible contraceptives (LARCs). On average, only 30% of clients were receiving counseling that included all the steps listed in the MOH FP counseling flipchart.
- Low FP continuation: Only about 25% of clients on average return to the VHTs on time for resupply or reinjection of a method.

Through a root cause analysis, stakeholders identified common reasons why women are not using family planning methods that are available and accessible through the VHTs. The reasons cited include opposition from male partners, side effects experienced by clients, and myths and misconceptions about family planning among men and women; these reasons are also supported by the literature.^{6,7} VHTs identified addressing side effects and misconceptions, as well as male involvement, as key to uptake and continued use of FP methods.

BOX 1. VHT PROFILE

- Bridge the gap between the community and health system
- Are volunteers nominated by their communities
- Can read and write in the local language and English
- Most have completed primary school or more
- Are attached to HCs and supervised by midwives
- Complete a 10-day FP training with a focus on services, especially safe injection techniques
- Can distribute short-term FP methods (cycle beads, pills, condoms, injectables, emergency contraceptives), make referrals for long-acting methods and provide counseling on all methods

^a A health center III should be found in every sub-county in Uganda. Each of these centers is led by a senior clinical officer who runs a general outpatient clinic and a maternity ward.



VHTs and midwives discuss the root causes of inadequate follow-up.

Design of the Improvement Collaborative for CBFP

To encourage uptake and sustained use of FP, FHI 360 designed and implemented an improvement effort based on the seven key features of the Institute for Healthcare Improvement's Collaborative Model:⁸

1. Common improvement aim and objectives.

Representatives of Busia's CBFP COE gathered in May 2015 to develop a QI Charter^b with the following aim: To increase the FP continuation rate from 25% to 80% among women of reproductive age (15-49 years) by May 2016 through the provision of high-quality CBFP services by VHTs.

2. Common improvement monitoring. In June 2015, APC introduced monitoring of CBFP QI indicators that address counseling on FP side effects, male involvement, couples counseling and retention of clients, among others (see **Results** section). The data are shared among team members, including the district's health-FP focal point, and charts depicting the results are posted on the walls of the three health centers.

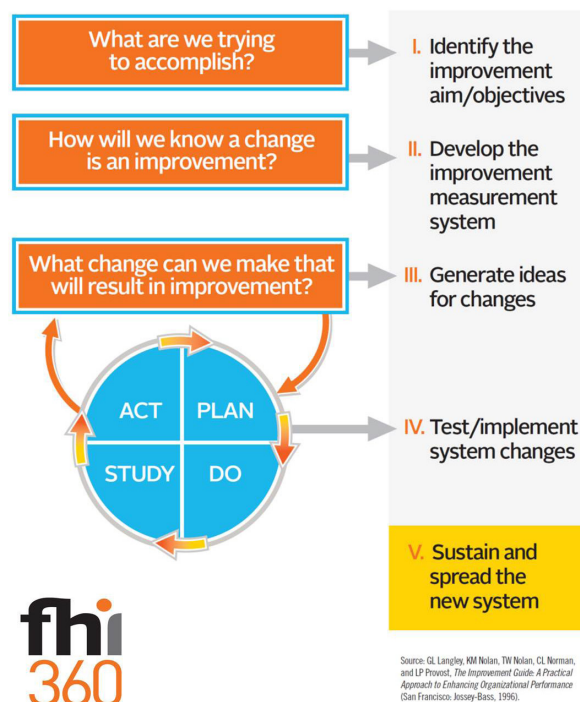
3. An operational structure. The CBFP COE established a QI team composed of the 36 VHTs, six HC staff members, selected FP client representatives and two district representatives each from Bulumbi, Buhehe and Buteba HCs. To enhance teamwork, the VHTs and the midwives who supervise them meet monthly to discuss indicators, challenges and improvements.

4. A coaching system for supporting the teams in implementing changes and measuring its effects. In December 2015, APC trained 52 coaches (a mix of VHTs, midwives, facility in-charges from the pilot health centers and four other health centers, as well as district health team members). The coaches are also champions who are expected to generate best practices and spread them through visits to new sites.

^b QI Charter – document that follows the Quality Improvement Model and states the stakeholders' consensus on aim, objectives, changes and operational structure.

5. A PDSA-based (plan, do, study, act) improvement model was applied to identify and implement changes and test their impact during specific action periods (see "FHI 360 QI Model").

FHI 360 Quality Improvement Model



6. A change package, which is a combination of explicit, evidence-based standards and best practices for the organization of service delivery. One change implemented by the team is direct observation by midwives of VHTs offering FP counseling (including counseling on LARC side effects) to clients during the VHTs' resupply visits. If no clients are present, the midwife role-plays as a client. The midwives use a checklist to assess the VHT's counseling skills and provide feedback.

7. Learning sessions that give teams opportunities to share their experiences, supported by data from monitoring, and learn about and plan how to replicate best practices. APC conducted the first learning session in December 2016 and plans to conduct others as the initiative is expanded to additional sites.

I have realized that engaging the client in discussions can help get more information on what to do to improve.

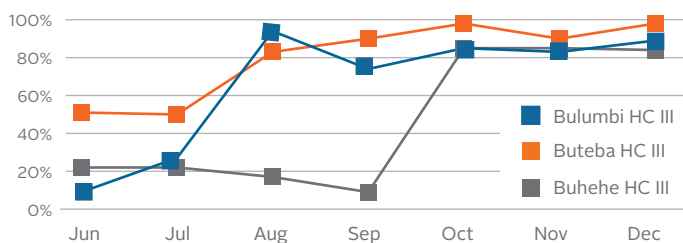
–Midwife, Busia District
12/2015

Results

The following results are based on an analysis of QI indicators collected by VHTs from three pilot sites for the period of June through December 2015. Some of the dramatic improvements shown in the graphs may be explained in part by better reporting, as well as enhanced services.

OBJECTIVE 1: All female clients (new and returning) receive adequate FP counseling services from the VHTs on the side effects of FP methods, including LARCs.

1. PERCENTAGE OF FEMALE CLIENTS ADEQUATELY COUNSELED FOR SIDE EFFECTS OF FP METHODS (JUNE-DECEMBER 2015)



Findings: VHTs reporting to Bulumbi and Buteba HCs have documented improved performance since July 2015 (see Graph 1). Buhehe started slowly, but began improving in October 2015. By December 2015, VHTs reported following all of the steps in the FP counseling checklist with more than 80% of clients.

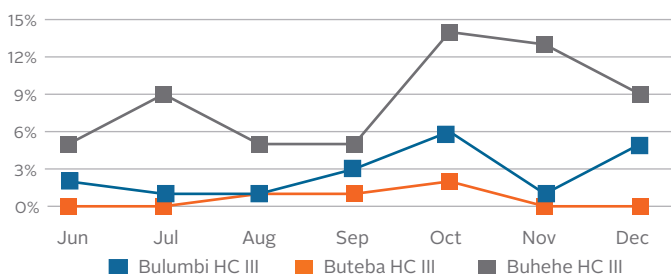
Issues reported by teams: Women often come in a rush to get an FP method and do not want to stay for counseling, because they are hiding FP use from their partners. VHTs tend to provide more counseling on the side effects of the short-term methods that they provide (e.g., pills and injectables), referring clients to midwives for counseling on LARCs, and some VHTs do not document the nature of the FP counseling they provide to clients.

Improvement may be a result of the following changes:

The VHTs started indicating the provision of adequate counseling in their registers and increased their use of the FP counseling flipchart. Also, mentorship by supervising midwives and monthly coaching sessions by APC during June to September 2015 refocused VHTs on stronger counseling skills and improved documentation.

OBJECTIVE 2: More female clients (new and returning) are counseled for FP with their partners as couples by the VHTs.

2. PERCENTAGE OF FEMALE CLIENTS COUNSELED AS COUPLES WITH A PARTNER BY THE VHTS (JUNE-DECEMBER 2015)



Findings: VHTs from Buhehe show greater improvement for this objective compared to VHTs in Bulumbi and Buteba (see graph 2). However, the percentage of women counseled with their partners remains low (<14%).

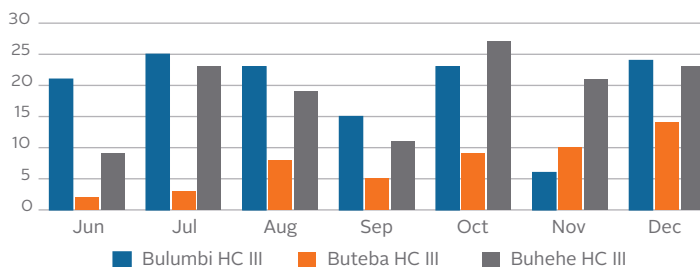
Issues reported by teams: Few men accompany their wives or female partners for FP counseling and services. In general, men do not support their spouses as a result of negative cultural norms, religious opposition to FP and numerous myths and misconceptions about FP methods. VHTs also fear they will be subjected to physical violence from men who do not want their wives to use FP, and provision of couples FP counseling has not been a priority for VHTs.

Improvement may be a result of the following changes:

During home visits, some VHTs use the opportunity to counsel women with their husbands and record the couples counseling in VHT registers. VHTs also counsel couples when women come with their partners on immunization and antenatal days. During the learning session, VHTs proposed using expert clients to encourage women to bring their husbands to FP appointments for couples counseling, if possible.

OBJECTIVE 3: More male clients receive FP information and counseling during interactions with VHTs.

3. NUMBER OF MALE CLIENTS RECEIVING FP INFORMATION, COUNSELING, REFERRAL OR METHODS FROM A VHT (JUNE-DECEMBER 2015)



Findings: VHTs from Bulumbi and Buhehe serve more men compared to the Buteba center. Cumulatively, VHTs from all three HCs were able to counsel 224 males, or an average of 46 men per month, over 7 months.

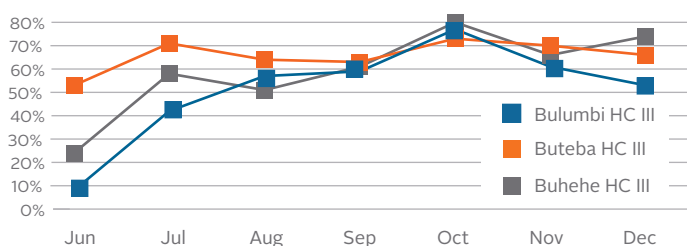
Issues reported by teams: Most men decline to be counseled because they believe that FP is for women and/or have negative attitudes toward FP.

Improvement may be a result of the following change:

VHTs started counseling men for FP when they came for condoms. During the learning session, VHTs developed one-minute "elevator speeches" for various male audiences (e.g., husbands, adolescents) that they can use to capture men's interest in the use of FP methods to protect the health of their families.

OBJECTIVE 4: More female clients return to the VHTs on the appointed date to continue use of an FP method.

4. PERCENTAGE OF FEMALE CLIENTS RETURNING TO A VHT FOR FP SERVICES DURING THE REPORTING MONTH (JUNE-DECEMBER 2015)



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- ⁴ Namaji C, Namaji M. Improving Maternal and Newborn Health in Uganda by Combining Training, Quality Improvement, and Peer-to-Peer Learning. Bethesda, MD, USA: Health Care Improvement Project; 2012.
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- ⁶ Darroch JE, Singh S. Trends in contraceptive need and use in developing countries in 2003, 2008, and 2012: an analysis of national surveys. *Lancet* 2013;381(9879):1756–1762.
- ⁷ Nanda K, Callahan R, Dorflinger L. Addressing gaps in the contraceptive method mix: methods in development. *Womens Health* 2015; 11(6):729–35.
- ⁸ The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. Boston: Institute for Healthcare Improvement; 2003

Findings: VHTs from all three health centers are improving their services, achieving a client retention level of over 50% from August through December 2015.

Issues reported by teams: About 30% of women stop using a method due to side effects or because their husbands disapprove of FP, according to the findings of the root cause analysis. VHTs report that most clients who drop out do so within the first three months.

Improvement may be a result of the following changes: VHTs look at the registry, check the return date and remind women about follow-up dates through home visits and informal meetings in the community. During the learning session, invited expert clients volunteered to share their experiences with new clients through testimonials at health talks that are usually conducted at the HCs. These testimonials may influence some women to continue FP use.

The Way Forward – Scale-Up

The Busia District's leadership has seen a positive trend in the performance of the VHTs. Therefore, the leaders agreed that APC should expand the QI initiative to four new level III health centers: Lunyo, Mbehenyi, Lumino and Busitema. In December 2015, the new HCs participated in a QI training and learning session for coaches and adopted the QI charter and processes. APC will support the scale-up through exchange visits for coaches between the pilot and new sites. In addition, APC plans to expand the CBFP QI process to one more district by April 2016.

APC will conduct a progress assessment of the CBFP QI initiative system-wide, together with the Busia District health team, QI teams and the central level MOH, to learn more about high-impact changes and recommend them for further scale-up and adoption in other districts. The results to date show that male involvement in FP remains low. APC will conduct a qualitative inquiry on men's knowledge, beliefs, perceptions and attitudes toward FP in Busia District, as well as analyzing the CBFP and QI indicator data. APC will also present key issues identified during the learning session in Busia to the MOH Quality Assurance Technical Working Group at the national level.

Working with VHTs presents different challenges compared to working at the facility level. For example, VHTs are volunteers. Most are semi-literate and have no previous data analysis or monitoring and evaluation experience. However, there are advantages to working with this more informal cadre. VHTs have a lot of enthusiasm and a level of creativity that is important to improving any processes. An innovative and key component of this approach is the inclusion of clients at every stage, including the assessment, charter development and learning session. Most important, through application of the QI collaborative methodology, the MOH and APC Uganda are continuously learning and capturing the learning needed to establish and scale up high-quality services and ensure the sustainability of the CBFP system. The experience in Busia District shows that the QI model can be effective in improving service delivery by VHTs.

Quality Improvement Team

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Advancing Partners & Communities

Advancing Partners & Communities (APC) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute, Inc., in collaboration with FHI 360