Date improvement activities began: November, 2009

Aims/objectives:

The aim of this collaborative was to continue to increase the availability and uptake of family planning (FP) services at MINSA facilities across Nicaragua, incorporate these improvements at CMP facilities, and spread the lessons learned and best practices identified through the family planning demonstration collaborative in Nicaragua implemented prior to this expansion collaborative.

Specifically, the collaborative aimed to increase the availability and use of long term methods, the intra-uterine device (IUD) and sterilization. Additional aims included identifying and capturing more high-risk patients, ensuring all women are able to make an informed choice in FP uptake under the Tiarht Amendment, and providing more opportunities to capture women for FP counseling outside of obstetric events. The objective was to achieve higher satisfaction among FP users at MINSA and CMP facilities. The collaborative aimed to maintain the 72% use of modern contraceptive use in the country.

Implementation package/interventions:

The following changes, first identified as best practices in the family planning demonstration collaborative, were implemented at participating facilities in the expansion phase:

1. Tiarht Amendment monitoring: In all participating municipalities, compliance with the Tiarht Amendment was monitored to ensure that all women are able to make an informed, free choice in family planning use. Facilities should have information material available for all patients that educates about various FP methods, through information sheets and posters. This is measured by how much information is available to women and how frequently informed consent is completed.

2. Informed consent: New forms were developed for informed consent for long term methods such as the IUD and tubal ligation. These forms are now used in all participating facilities.

3. Increase availability of IUDs: IUDs are now available in MINSA health centers, health posts, and hospitals. At MINSA facilities, doctors, OB nurses, or nurses can insert the IUD. At CMP facilities, insertion must be done by a doctor or OB nurse. Additionally, MINSA is promoting the use of the IUDs as a family planning method.

4. Development of job aids: HCI developed banners and posters that promoted various FP methods posted at clinics. A quick guide for users was developed to complement counseling.
5. Clinical eligibility: Prior to 2008, the clinical criteria for eligibility for FP methods were not included in the MINSA norms. HCI lobbied for the inclusion of criteria in the norms and participated in their development. 6,000 copies were delivered to MINSA and CMP clinics. HCI trained providers on the norms as soon as they were issued in draft form. Clinical forms were designed to remind providers to complete FP counseling.

6. Modification of clinical forms: Clinics adapted MINSA forms to their own needs, which allowed them to collect specific data to analyze for quality improvement activities. A tracking sheet was designed to capture what method a woman used and what her birth outcome was to measure access to various methods. Management used this sheet as a data tool to show deficiencies at their facilities and differences in equitable access to methods.

7. Create more opportunities to provide FP counseling: Prior to the collaborative, there were many lost opportunities to provide FP counseling, especially outside of obstetric events. Facilities worked to improve follow-up and create more counseling opportunities by giving women appointments specifically for FP, calling patients to remind them of these appointments, and discussing optimization of FP counseling within the patient care flow at the facility. As a part of this activity, QI teams analyzed facility data to determine additional points in the care spectrum where FP counseling opportunities were lost so that these could be included.

Several other changes were also expanded from the first demonstration phase. The collaborative worked with facility and network management teams to improve the management of supplies so that more methods were available more consistently, an important modification to provide women with the method of their choice, including IUDs as noted above. The problem of frequent stockouts was addressed from a network perspective and all FP method offerings were organized at the facility level, which made measuring supplies easier. These measurement tools made it easier for facility managers and providers to discuss what supplies they needed at their local clinics. A special emphasis was put on identifying and capturing high-risk patients.

In addition to best practices identified during the first phase, new changes were implemented at facilities participating in the expansion phase:

1. HCI developed new forms for IUD and sterilization informed consent, which are now used in all MINSA and CMP facilities across Nicaragua.

2. Education: HCI developed several radio vignettes about different FP methods, played around the country. The vignettes educated users on what different methods were available, how each method works, where methods are available, and that they are free of charge at all MINSA and CMP clinics. Additionally, in eight SILAIS, HCI collaborated with facilities to make a video about sterilization that was shown in clinic and hospital waiting rooms. The video described the sterilization procedure and its risks.

3. Inclusion of male partners: HCI promoted the inclusion of men in birth plans and ante-natal care, which includes post-obstetric family planning. This encourages more men to participate in FP counseling with their partners. This also provided an immediate opportunity for couples to discuss sterilization with their partners.
4. Links with HIV programs: HIV provided training to multi-disciplinary HIV teams in 15 participating hospitals so that these providers could also provide FP counseling to ARV patients, creating another point of service where patients could access FP.

5. Support for adolescents: MINSA provided extra support for pregnant adolescents to ensure continuation of their chosen post-obstetric method.

6. Support for patients who choose Lactational Amenorrhea Method (LAM): MINSA began to conduct home follow-up visits for patients who chose LAM to provide targeted support to these users, as well as encourage them to choose a new method at 6 months when LAM is no longer effective.

Measurement:

The indicators used to measure impact in this collaborative were as follows:

- % of women accessing MINSA facilities using modern contraceptives
- % of women accessing CMP facilities who receive FP services and methods
- % of women using a hormonal contraceptive after an obstetric event
- % of women using double protection after an obstetric event
- % of women using an IUD with informed consent after an obstetric event
- % of women undergoing sterilization with informed consent after an obstetric event
- % of MINSA primary and secondary health facilities that offer long term contraceptive methods (IUD and sterilization with local anesthesia)

Spread strategy:

This collaborative was the expansion phase of a previous demonstration collaborative in family planning. The further lessons learned and improvements from this collaborative were adapted by MINSA and applied in other facilities not participating in the collaborative. Throughout the collaborative, new centers were incorporated and began participation and uptake of the improvement practices.

Number of sites/coverage:

In the expansion phase, teams from 16 of 17 SILAIS participated in the collaborative. This included 17 hospitals and 16 MINSA health centers. 16 CMP clinics, one from each participating SILAIS, were also included in this phase.
Coaching:

There were four types of teams that participated in the collaborative: hospital teams, SILAIS teams, CMP teams, and municipal teams. Each of these teams received direct coaching from QI coaches. During these visits, coaches worked with facility teams to better organize services and supplies, how to analyze data for quality improvement, and how to resolve other relevant issues identified by coaches.

Learning sessions & communication among teams:

Learning sessions were held within individual SILAIS and were an opportunity for all participating teams in a SILAIS to discuss the changes they had implemented and resulting improvements. Each facility participated in two learning sessions. These sessions created an opportunity for facilities serving similar populations to communicate with each other. Several teams also participated in facility exchanges, where a team from a hospital facing difficulties implementing a specific change would visit a hospital that had successfully implemented that change. This allowed these teams to better understand first-hand how changes could be made.

Results:

The compliance with post-obstetric event (POE) family planning protocols in reported health units is above 90%; post-partum women who received counseling before discharge and were discharged with a contraceptive method increased from 76% in January 2009 to 92% in September 2010. There was an increase in the number of providers who use clinical eligibility criteria, the 87% average compliance of this standard has been maintained since 2009 in 53 out of the 130 municipal units at the national level. Data for POE IUD insertion show an increase in use, from 1% in January 2009 up to 8% in September 2010 in health units from both care levels in 10 of 17 SILAIS in the country.

Counseling provided according to FP norms and protocols has created an increase in the number of users who receive information on consistent condom use as a contraceptive method that also prevents sexually transmitted infections (STIs). A 19% increase in users who receive this information was observed during the collaborative, going from 63% compliance in January 2009 with 12 health units to 88% in September 2010 with 53 health units.

From October 2010 to September 2011, 10,203 teenagers received post-partum care in 15 hospitals, representing 26% of all post-partum patients. 82% of teenagers were discharged with a modern contraceptive method. Among all teenage FP users, the most commonly used methods were hormonal (40%), condoms (25%), IUDs (10%) and natural methods (10%).

Among reporting facilities, MOH health units providing care for obstetric events are providing FP counseling to 100% of postpartum women and assuring delivery of their chosen method, before discharge. Currently 33 health units in 16 SILAIS offer sterilization. 12,540 female surgical sterilization procedures have been performed of a total of 73,176 postpartum women discharged with a
Best practices/conclusions:

Teams had great success with creating and using their own forms. By designing forms themselves, teams were able to identify their needs, make forms that best fit those needs, and as a result were more likely to complete them correctly.

The coaching visits were especially helpful for teams because they were able to approach issues specific to their facility in depth. This led to more profound, better learning around improvement techniques and best practices.

Intra-SILAIS learning sessions also allowed for more focused sharing between teams because many of these facilities have similar patient populations. By connecting facilities within the same SILAIS, these sessions strengthened the concept of a network around a hospital. For example, in Chinandega, a learning session included two private hospitals, public hospitals, CMP social security clinics, and MINSA clinics. These facilities were able to work together to discuss solutions to issues in family planning that all of the clinics faced.

Several difficulties were identified during the work of this collaborative. First, many doctors felt they were not properly trained in how to provide sterilizations. Increased clinical in-service training on sterilizations addressed this problem.

It is important to verify that providers feel sufficiently skilled in providing various methods. A significant problem was that family planning was often only considered as a post-obstetric need, and not at other points in the reproductive cycle, in both hospitals and municipalities. Because MINSA was not collecting data about how family planning provision outside of post-obstetric events, many facilities felt it was less important. However, when MINSA changed data forms, there was a notable change in attitude.

Employing quality improvement methodologies generated change at facilities. When directors analyzed data, they were more likely to use that information in a meaningful way to implement sustainable changes. There was greater institutionalization as directors and hospital management felt more empowered. Seeing data links, such as between lower maternal mortality and increased FP provisions, helped providers better understand collaborative goals.

Tools are important way to support and reinforce changes. Checklists work especially well to facilitate the collection of relevant data. Providers found that a checklist was useful for determining clinical eligibility and identifying the risk factors associated with specific methods. The availability of a rapid guide on different FP methods was also key in achieving improvements.
Providing FP counseling and provision training to a multi-disciplinary HIV hospital team allowed facilities to reach a greater high-risk population. This new link provided better integration of care for HIV patients, who could receive FP counseling from providers they already trusted.