Resource December 12, 2011

Nicaragua | Family Planning Demonstration Collaborative

Date improvement activities began: February, 2009

Date of end of collaborative: November, 2009

Aims/objectives:

The aim of this collaborative was to increase the availability and uptake of family planning (FP) services at MINSA hospitals and clinics in eight SILAIS, or health regions, in Nicaragua. Specifically, the collaborative aimed to increase the availability and use of long term methods, the intra-uterine device (IUD) and sterilization, and the use of MINSA clinical norms for the offering of all FP methods. Another aim was to improve providers' registration of FP counseling and methods used. 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 facilities. The collaborative aimed to maintain the 72% use of modern contraceptive use in the country.

Implementation package/interventions:

Under this collaborative, the following changes were implemented at participating facilities:

1. Tiahrt Amendment monitoring: In all participating municipalities, compliance with the Tiahrt 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.

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.

Measurement:

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

- % of women accessing MINSA facilities using modern contraceptives
- % 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 tubal ligation with local anesthesia)

Spread strategy:

The best practices and lessons learned during this improvement experience were translated for MINSA and presented to additional facilities across Nicaragua so they could apply changes to improve the quality of family planning services. This work resulted in an expansion phase, which began in November 2009 when this demonstration phase concluded.

Number of sites/coverage:

This collaborative worked in 8 of 17 SILAIS in Nicaragua. 8 hospitals and 8 health centers participated, with one hospital and one health center participating from each SILAIS.

Coaching:

Each hospital and clinic team 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.

Learning sessions & communication among teams:

Learning sessions were held within individual SILAIS and were an opportunity for all participating facilities in a SILAIS to discuss their improvements. Each facility participated in four learning sessions. This created an opportunity for facilities serving similar populations to communicate with each other.

Results:

HCI began to introduce the new FP clinical forms to participating teams before they were formalized as norms by MINSA in November, 2008. Because of this early introduction, these facilities were immediately able to achieve 80% compliance with counseling and registration protocols. The forms were specially designed work as a job aid for providers that reminded them to include FP counseling and prescription.

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.

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