Uganda Improvement Collaborative: Integration of Family Planning into Maternal and Neonatal Health Programming

STRIDES and E2A

STRIDES for Family Health (STRIDES) is a USAID-funded project implemented in Uganda from 2009 to 2015 by Management Sciences for Health and its core partners: Communication for Development Foundation Uganda, Jhpiego, and Meridian Group International. Supporting the Ministry of Health and its private sector health partners, STRIDES aims to improve the quality of care and increase access to integrated reproductive health, family planning, child survival, and nutrition services in 15 districts.

The Evidence to Action (E2A) Project is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services. E2A is led by Pathfinder International in

Introduction

Rates of maternal and neonatal mortality are high in Uganda. In much of the country, high-impact best practices in maternal and newborn health and family planning have yet to be implemented, and quality of care is poor. To address these issues, the Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A) project partnered with the STRIDES for Family Health (STRIDES) project, and Uganda's Ministry of Health (MOH) to introduce and implement an Improvement Collaborative (IC), a systematic approach for introducing and scaling up best practices. The IC was designed around an integrated package of maternal, neonatal health, and family planning best practices delivered at hospitals and high-tier health facilities (facilities III and IV) in Uganda. This technical brief describes the process and results of the IC introduction.

Health Context

Uganda faces significant obstacles to reaching Millennium Development Goals 4 and 5, which focus on improving maternal and child health. While the country is making progress in increasing immunization coverage and reducing the infant mortality rate, maternal and neonatal mortality ratios are high. In 2011, the maternal mortality ratio was 438 deaths per 100,000 live births; the neonatal mortality ratio was 27 deaths per 1,000 live births, and the infant mortality ratio 54 deaths for every 1,000 live births. Despite these statistics, there are signs that maternal and newborn health care is improving, with the percentage of births assisted by skilled providers increasing from 42% to 58% during the five-year period from 2006 to 2011(*Uganda Demographic and Health Survey*, 2011).

Uptake of family planning, a proven intervention for reducing maternal and neonatal mortality, is quite low. Only 30% of married women aged 15 to 49 use a modern family planning method and 34% of married women continue to experience an unmet need for family planning. The Government of Uganda has set a target in its Health Sector Strategic and Investment Plan to reduce unmet need among married women to 20% by 2015 (UDHS, 2011). To address Uganda's high unmet need for family planning, high maternal and neonatal mortality ratios, and low contraceptive prevalence rate, STRIDES and E2A introduced an IC, which aimed to improve quality and expand the provision of high-impact maternal and neonatal health and family planning interventions.

The Improvement Collaborative

The IC is a structured quality improvement (QI) approach that organizes a number of teams or health facilities to work together for a period of 18 to 24 months to achieve significant improvement in a specific area of care. The intention is to accelerate both the pace and geographic spread of the technical package, even in the context of weak health systems facing severe material and human resource constraints. The IC methodology focuses on collaborative efforts of health facility teams that learn together, rather than individual sites working on their own. The IC approach combines traditional QI methods of team work, process analysis, introduction of standards, and measurement of quality indicators. The IC relies on training, job aids, and coaching, encouraging shared learning through regular learning sessions and the diffusion of innovations.

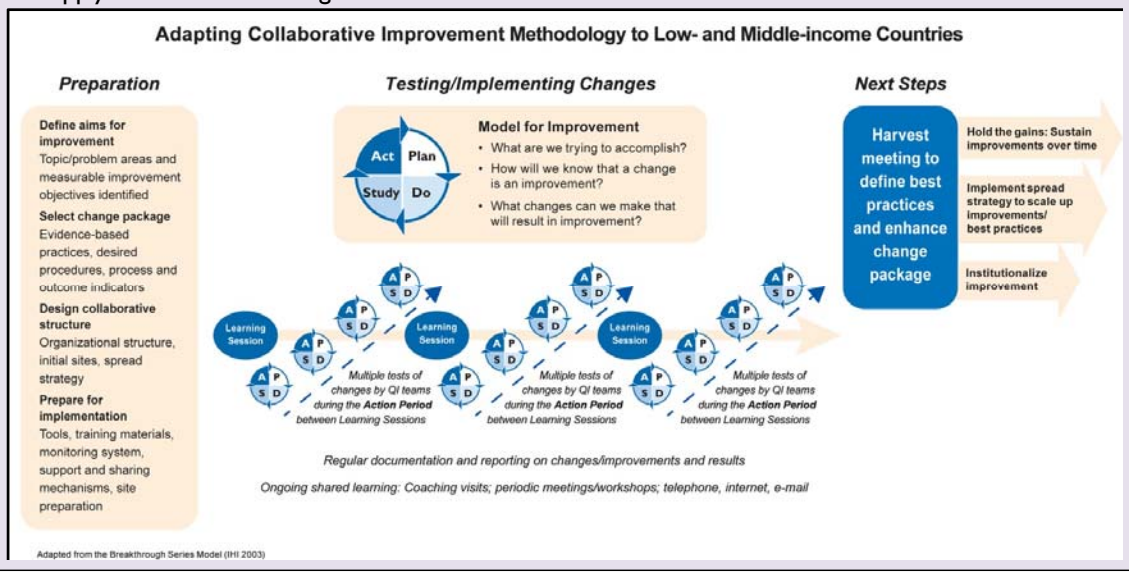
Essential Features of an Improvement Collaborative

- Improvement objectives
- Organizational structures
- Initial implementation package
- Spread strategy
- Qualified and functional quality improvment teams
- Monitoring system for quality of process and results
- Regular support to quality improvement teams (coaching)
- Opportunities to share experiences and results (learning sessions)
- Tested implementation package with operational changes

The IC was selected for the following reasons:

1. Proven effect on improved quality and building of local capacity and country ownership, which also supports institutionalization of the selected best practices.
2. The selected best practices were facility based, which was beneficial for the creation and capacity building of QI teams who already worked together on a daily basis. Since the QI teams were interacting regularly, there was no need to hold additional meetings at an added cost.
3. The MOH highlighted the importance of using the IC methodology in its national QI strategy, and therefore greater MOH support was expected.

The **Improvement Collaborative**[1] is a methodology where improvement teams from different clinics, hospitals, and other levels of the health system work together on common aims to improve particular aspects of the system. Members share experiences as they test changes for improvement and apply the successful changes on a wider scale.



[1]The Improvement Collaborative was first implemented by the Institute for Health Improvement and further developed by University Research Corps, LLC. The USAID-funded Extending Service Delivery (ESD) Project, which was implemented from 2005 to 2010, then tailored the approach for use in several Asian, Middle Eastern, and African countries. E2A built on the work of ESD to tailor the approach for application in Uganda.

Implementation of the Improvement Collaborative in Uganda

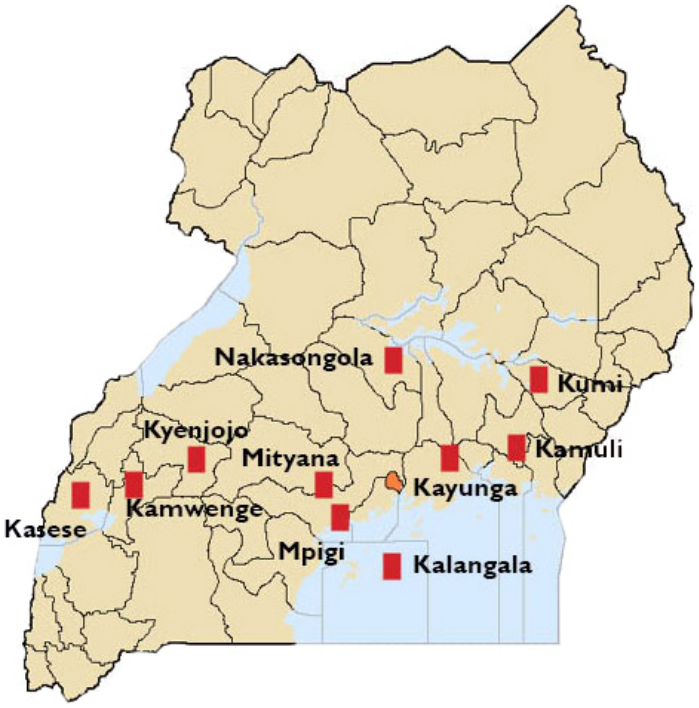
Formation of Implementation Teams

The IC began with a preparatory phase, during which STRIDES, E2A, and district health officials formed district QI teams. The district QI teams were charged with guiding the IC facility QI teams and the IC process at the health facilities. The district-level QI team leaders (district health officials) acted as collaborative coordinators, providing strategic direction for QI, mobilizing support, and liaising with key partners to ensure IC implementation throughout the district. District QI team members were responsible for coaching and mentoring the facility QI teams to implement action plans they had developed and address challenges.

Facility QI teams were formed at all of the participating health facilities with representatives from the maternity units, laboratories, antenatal and family planning clinics, records and administration. They identified performance gaps, and subsequently analyzed and implemented solutions to address those gaps. The facility QI team leaders (facility managers or in a few cases senior service providers) ensured team functionality, assigned roles, led meetings, liaised with management, provided technical expertise, and solved problems at the facility.

District and Facility Selection

District leaders such as district health officers and the district health management teams were also significantly involved in the selection of the IC demonstration districts and facilities. Ten districts were selected, as indicated in the map: Kamuli, Kumi, Kayunga, Kalangala, Mpigi, Mityana, Nakasongola, Kamwenge, Kyenjojo, and Kasese.



Districts

The demonstration IC was implemented in two phases or groups. Group I included two districts (Mityana and Nakasongola), while Group II included facilities from eight districts. Selection of districts was based on the following criteria:

- Strong need and desire for QI initiatives to address gaps in service-delivery performance expressed by the district health teams.
- Absence of other partners or programs implementing similar QI interventions, particularly in the areas of reproductive health, child health, and family planning services.
- Close proximity to STRIDES' headquarters office to facilitate documentation and monitoring of experiences and lessons learned during the demonstration process.

Facilities

Group I included 10 facilities from two districts. Group II included 36 facilities from eight districts. The IC introduction reached 46 health facilities from 10 districts in the eastern, central, and western regions of Uganda (see map on previous page for the geographic spread of the IC introduction). Facility selection was based on the following criteria:

- Availability of defined clinical package of essential and comprehensive obstetric care, neonatal care, and postabortion care.
- Selecting a mix of public and private sector services that offered adequate coverage for the population within the 10 districts to test implementation of the interventions in different sectors before scaling them up.
- The targeted facilities included three tiers of health service delivery in Uganda: (1) two types of health centers (levels III and IV)—both of which offer preventive, curative, maternity, inpatient, outpatient, and laboratory services; and (2) hospitals. There were 16 level III health centers, 18 level IV health centers, and 12 hospitals.

Introduction of the Improvement Collaborative

The IC methodology prescribes a phased approach, beginning with a demonstration phase in a select number of facilities, followed by an expansion phase to more facilities over a period of 18 to 24 months. The objective of this staggered implementation is to first test the selected best practices and produce effective changes (the demonstration sites), and subsequently utilize the knowledge and skills gained by the demonstration sites to spread these effective changes to a larger number of facilities (the expansion sites).The ultimate goal is for the expansion sites to integrate the technical package at a faster rate than the demonstration sites, exemplifying the effect of collaborative learning.

The approach was first applied in the two districts (Group I), with the ultimate goal of expanding to the remaining STRIDES project districts after one year of implementation. However, since the STRIDES project was moving into its final year of implementation in 2013, the demonstration sites were expanded after three months to include eight additional districts (Group II). This limited the time frame between the implementation of Group I and Group II. E2A and STRIDES therefore worked with 46 demonstration facilities for one year, instead of one group of demonstration facilities during the first 12 months, followed by another group of expansion facilities during the next 3 to 6 months. The approach did not allow for a systematic review of Group I facilities' performance before the implementation in Group II, and experiences and lessons learned were only shared informally.

Facility and district QI teams from both groups took part in an IC introduction workshop (Group I in March 2012, and Group II in June 2012), led by E2A and facilitated by STRIDES. During the Group I workshop, participants refined the overarching goal for this particular IC: contribute to reducing the high maternal and neonatal mortality and significant unmet need for family planning in Uganda. The Group I workshop also resulted in the development of the technical implementation package, which consisted of:

- Improvement objectives and a list of best practices that contribute to meeting these objectives (see table below).
- Guidelines and job aids to respond to the best practices included in the implementation package.
- Indicators to monitor and measure IC progress (discussed in the results section).

Improvement Objective	Best Practices
Increase contraceptive use among women of reproductive age.	• Counseling for and provision of family planning methods to postpartum women after delivery and before they leave the facility • Counseling for and provision of family planning methods to women as part of the postabortion care package • Maintain adequate stock levels of correct contraceptive mix for each level of care
Reduce maternal deaths from common causes: postpartum hemorrhage, obstructed labor, sepsis, and eclampsia.	• Monitoring labor using a partograph and managing complications • Active management of the third stage of labor • Provide regimen of iron and folic acid to every postpartum mother before they leave the facility • Deworm every postpartum mother
Reduce neonatal deaths from perinatal complications.	• All newborns receive Essential Newborn Care (cord care, thermal care breastfeeding within 30 minutes of birth, vitamin K, tetracycline eye ointment, and BCG/Polio immunization)
Use infection control as cross-cutting best practice for entire package of clinical services.	• Comply with infection prevention standards while providing the integrated package of services

Additionally, because Group I facilities started implementation three months prior to Group II facilities, Group I workshop facilitators and participants (composed of district and facility QI teams) developed the IC organizational structure, coaching and mentoring plans, action plans for the IC demonstration facilities, IC monitoring and evaluation plan, and site selection criteria for Group II facilities. Both Group I and Group 2 facilities were coached and mentored by district QI teams that were described above under team formation

Implementation of the Improvement Collaborative

Implementation of the IC focused on capacity building in four major QI areas. These include: coaching and mentoring of facility QI teams, clinical aspects of the implementation package, data collection, data quality, and use of data for decision-making and learning sessions for shared exchange of knowledge.

Coaching and Mentoring of Facility Teams

Within the IC, coaching focuses on aspects of QI (working in teams, using data for decision-making, and testing changes), while mentoring focuses on clinical standards and whether service providers are properly applying those standards. Coaches from the district QI teams regularly supported the facility QI teams through bi-monthly meetings. The coaching sessions assessed team composition, clarified roles, and ensured that the facility QI teams were intact and functioning properly. Coaches also emphasized problem-solving skills and effectively working in teams. Mentors from the district QI teams conducted on-the-job clinical training, as needed, which included facility observations to determine if staff were abiding by clinical standards, and providing support with immediate feedback.

E2A and STRIDES tailored an IC coaching guide for use with the demonstration facilities during the coaching and mentoring sessions. The guide helped assess the functionality of the QI teams, to what extent the action plans had been implemented, challenges, and recommendations. The coaching guide also contained a short checklist for conducting inventories of essential medicines, equipment, and supplies for provision of maternal, neonatal, and family planning services, as specified in the technical implementation package.

Clinical Aspects of the Implementation Package

The STRIDES team, MOH coaches and mentors conducted continuous on-the-job training in the clinical aspects of the implementation package. The sharing of guidelines, checklists, and job aids among targeted facilities contributed to knowledge-building, and the learning sessions built clinical capacity, focusing on gaps in clinical knowledge and practice.

Data Collection, Data Quality, and Use of Data for Decision Making

During QI trainings and learning sessions, facility QI teams became familiar with the indicators they would use to measure progress. The facility teams then worked with their coaches and mentors to develop a matrix that contained the list of best practices and corresponding indicators, as well as the indicator definitions and sources of data. The indicator definitions were reviewed during each coaching visit to ensure proper understanding and accuracy of the data collected.

Baseline data were collected from January to March 2012. Facility QI teams were encouraged to collect data for at least four main indicators:

- Family planning counseling and provision of methods during the immediate postpartum period;
- Monitoring labor using a partograph;
- Active management of the third stage of labor (AMTSL); and
- Provision of essential newborn care (ENC).

E2A and STRIDES developed a tool to assist the facilities in capturing data on a weekly basis from each service point, which could then be used to populate the monthly register with facility data. The data were routinely validated for quality during each coaching visit by randomly selecting a few records and verifying them for accuracy. Mentors and coaches emphasized the use of data for decision making during coaching visits and learning sessions. Facility QI teams received training on the use of documentation journals, a critical tool for data collection and monitoring. The journals allowed the teams to document their challenges, gaps, tested changes, and results. The data were then plotted as a linear trend chart to assist the QI teams in analysis of challenges and progress.

Learning Sessions for Shared Exchange of Knowledge

Three-day learning sessions were conducted after each six-month period to enable participating sites to share accomplishments and lessons learned, as well as to adopt effective local practices for implementation within the health system. Additionally, the facility QI teams identified effective changes during the learning sessions, which they documented and adopted for implementation. To maximize learning and collaboration, facilities from three to four districts gathered at a central location for the learning sessions.

Significant outcomes from the learning sessions were:

- All teams received guidance on QI tools, indicator definitions and calculations, data verification and reporting, and plotting of trend charts for analysis.
- Clinical updates on the selected best practices—including family planning methods provided during post-abortion care or the immediate postpartum period, how to use a partograph and the protocol for helping babies breathe—were shared.
- Facility QI teams shared effective changes tested during the past action period, which encouraged other teams to test the same changes in their facilities (see box to the right for the specific practices).

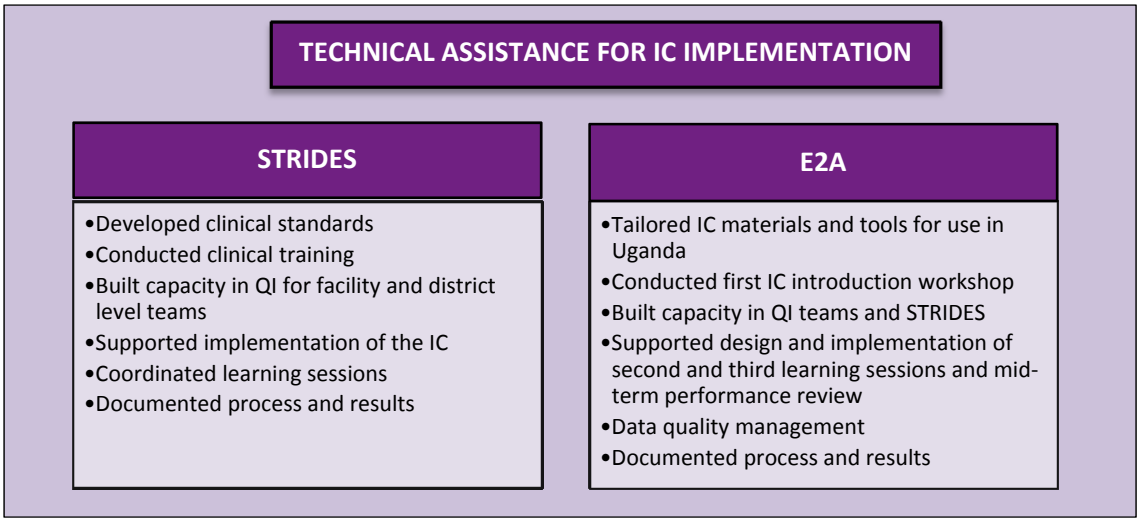
Effective Changes for Improved Quality of Care

- Address stock-outs in Oxytocin and other supplies by:
  - Borrowing from higher-level facilities;
  - Ensuring timely requisition of supplies.
- Address stock-outs of partographs by ensuring a sufficient number of photocopies are available (using facility PHC funds).
- Reach out to village health teams and community health workers to improve referral systems.
- Hang reminders on the walls to comply with the clinical guidelines.
- Add a column to the maternity register to record family planning counseling and use.
- Hang reminders on the wall for mothers and providers to respectively request and provide family planning counseling before discharge.

- Teams developed workplans for the next action period, which included effective changes and solutions to challenges that the facility QI teams discussed during the learning session.
- Quality improvements were accelerated primarily as a result of shared learning, but also due to the positive competition during the learning sessions, as champion facilities acted as role models for other QI teams.

Technical Assistance Collaboration: STRIDES and E2A

STRIDES and E2A supported the IC implementation through consistent technical assistance. In addition, STRIDES provided partographs, maternal and perinatal audit forms, updated maternity registers, and tools for documenting and monitoring data. The project also provided basic equipment and infrastructure for the renovation of outpatient units, maternity wards, operating theaters, water storage, and waste disposal in selected health facilities. The box below describes specific details about the technical assistance provided and clarifies how global and local partnerships are synergistic.



Results

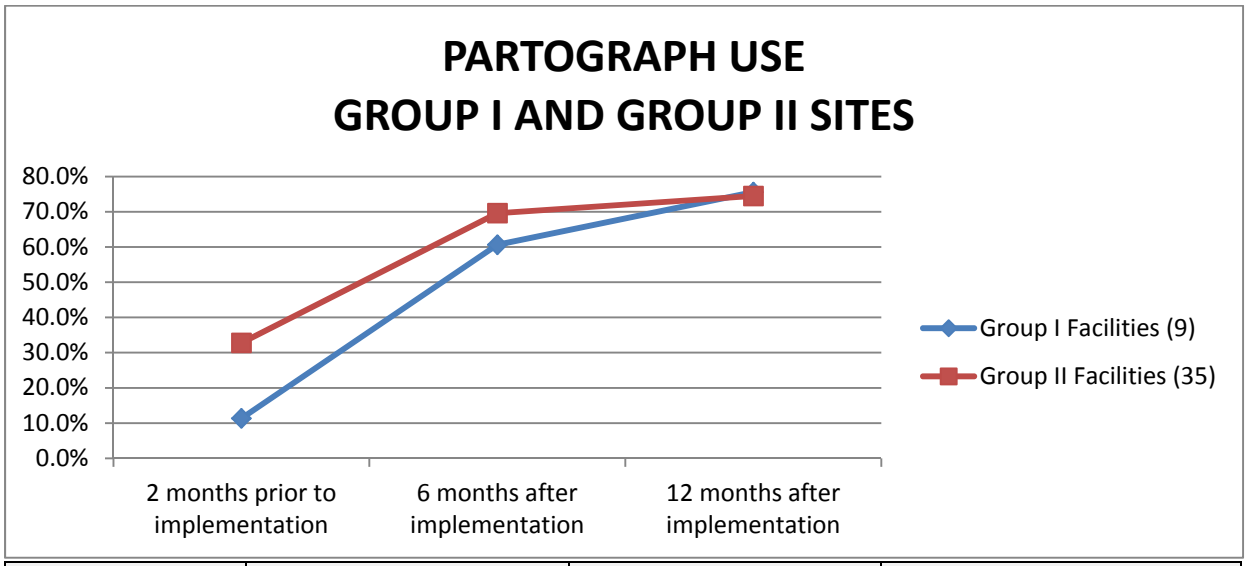
As described previously, the IC demonstration phase was introduced in two groups: Group I in March 2012 and then Group II in June 2012. Facilities submitted data from January 2012 to June 2013. The baseline measurement of indicators was taken two months prior to the implementation of the IC (Group I: January 2012; Group II: April 2012), midline at six months after implementation of the IC (Group I: September 2012; Group II: December 2012), and the endline measurement at 12 months after implementation of the IC (Group I: March 2013; Group II: June 2013).

Five indicators were selected for analysis: (1) partograph use; (2) application of AMTSL; (3) application of elements of ENC; (4) postpartum family planning (PPFP) counseling; and (5) PPFP uptake. The target for partograph use, application of AMTSL and ENC, and PPFP counseling was 100%, as these services should be offered during every delivery. No target was set for PPFP uptake to avoid undue influence and coercion. Despite setting this ambitious target, the one-year demonstration period (instead of the 18- to 24-month period usually set for an IC) did not allow the participating facilities enough time to reach that goal for the four indicators.

A total of 46 facilities took part in the introduction of the IC approach; 10 facilities in Group I and 36 facilities in Group II. For the purposes of data analysis, however, not all facilities were included due to missing or incomplete data. The analysis of partograph use, application of AMTSL, and ENC include 9 Group I facilities and 35 Group II facilities. The analysis of PPFP counseling and uptake includes 9 Group I facilities and 31 Group II facilities. Each of the five indicators is analyzed below.

Partograph Use

The results for partograph use showed significant increases from baseline to endline. Group I facilities increased partograph use from 11% at baseline (for the month of January 2012) to 76% at endline (for the month of March 2013). Group II facilities also showed excellent progress with a baseline measurement of 33% (April 2012) that increased to 75% (June 2013) at endline. Remarkable achievements were made by the facilities; they worked to achieve a target of 100% for partograph use by encouraging staff, particularly permanent staff, to use the partographs as a routine part of monitoring every delivery. Facility QI teams are also working to orient new staff as soon as they arrive on use of the partograph to counter high staff turnover at these facilities.

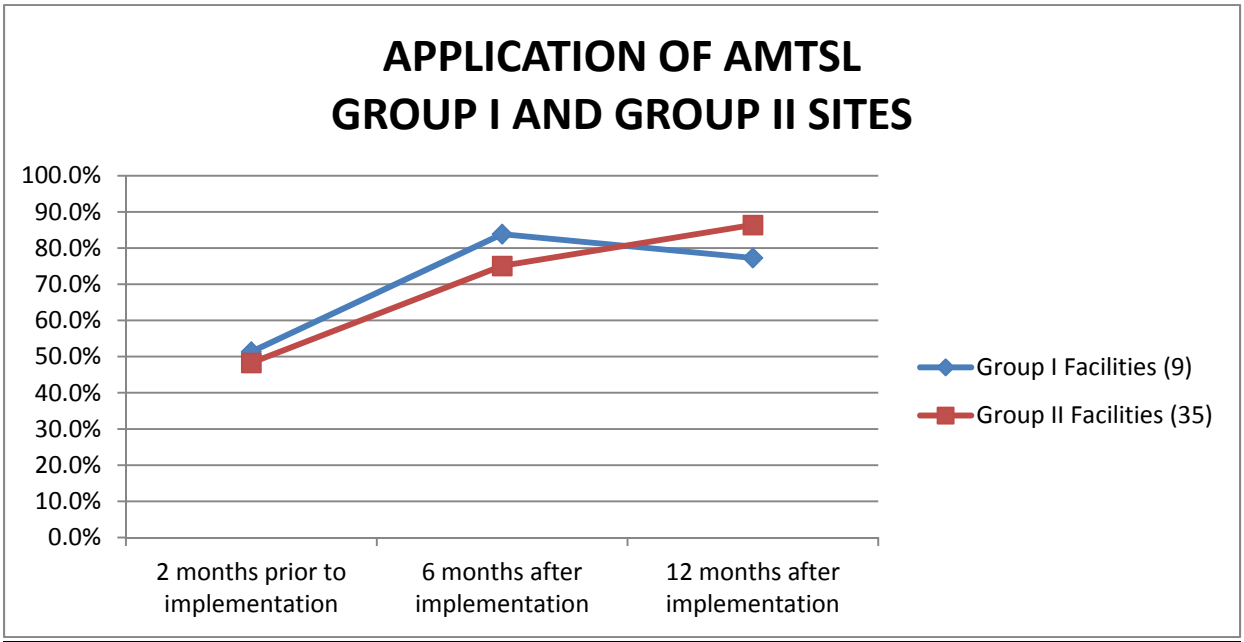


	2 months prior to implementation		6 months after implementation		12 months after implementation	
	GI	GII	GI	GII	GI	GII
# of deliveries at facility in which a partograph was used	21	768	97	1,822	133	1,884
Total # of women who delivered at the facility	185	2,344	160	2,618	176	2,530
Percent	11.4%	32.8%	60.6%	69.6%	75.6%	74.5%
Group I (GI): 9 Facilities; Group 2 (GII): 35 Facilities						

Application of AMTSL

Group I and Group II facilities showed improvement in the application of AMTSL from baseline to endline. Group I facilities increased AMTSL application from 51% at baseline (January 2012) to 77% at endline March 2013). Group II facilities increased AMTSL application from 48% at baseline (April 2012) to 86% at endline (June 2013).

Staff at the facilities built on their new ability to use the clinical standards for AMTSL and strove to reach a target of 100% for AMTSL application. Additionally, during their mentoring sessions, staff learned how to be proactive about preventing Oxytocin stock-outs—a major hindrance to full application of AMTSL—by using facility resources to order and purchase the drug.

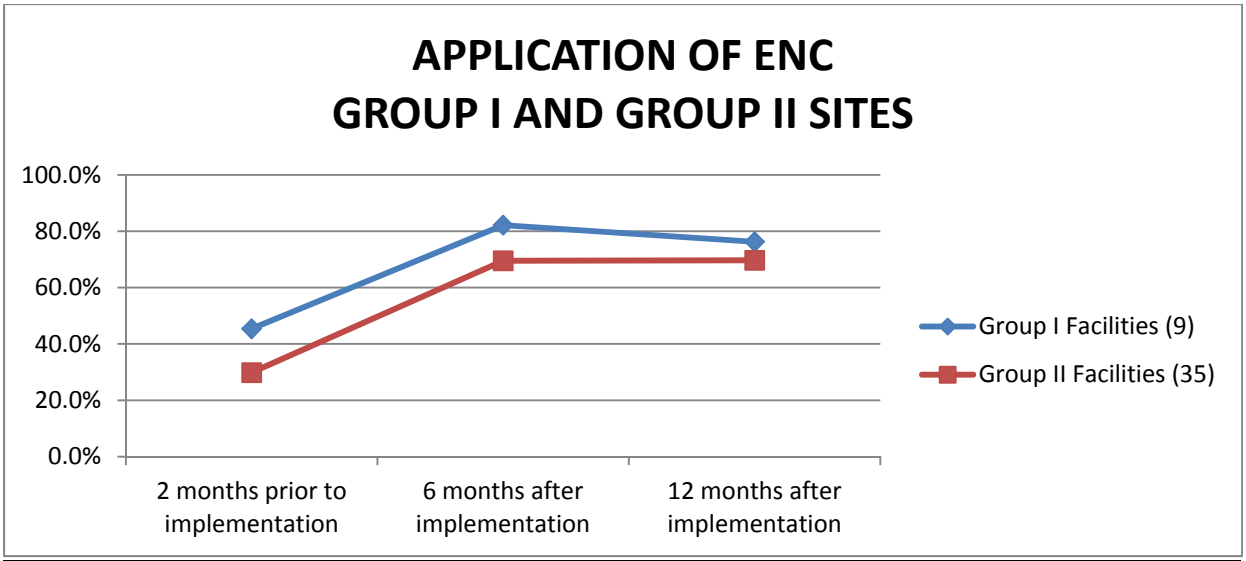


	2 months prior to implementation		6 months after implementation		12 months after implementation	
	GI	GII	GI	GII	GI	GII
# of deliveries at facility in which AMTSL was applied	95	1,147	135	2,018	136	2,140
Total # of women who delivered at the facility	185	2,376	161	2,688	176	2,477
Percent	51.4%	48.3%	83.9%	75.1%	77.3%	86.4%
Group I (GI): 9 Facilities; Group 2 (GII): 35 Facilities						

Application of ENC

Group I facilities experienced a marked increase in the application of ENC, from 45% at baseline (January 2012) to 76% at endline (March 2013). The Group II facilities increased ENC application from 30% at baseline (April 2012) to 70% at endline (June 2013). Facility staff actively tested solutions that will allow them to arrive at the 100% mark for application of ENC. For example, some facilities used partographs to record ENC, and ensured that there were a sufficient number of partographs. To address stock-outs of Vitamin K and other vaccines, facility QI teams advocated to district health officers so that they could urge higher-level stakeholders to ensure adequate supply of these essential medicines.

Facilities also specifically addressed challenges related to the BCG vaccine, one element of ENC. Because the BCG vaccine is packaged in an ampoule that contains 20 doses (and all doses need to be administered within 6 hours once the ampoule has been opened), facilities experienced problems with wastage of the vaccines. E2A therefore shared practices from other countries that successfully administer the vaccine, including encouraging postpartum women to stay 24 hours at the facility and vaccinating multiple newborns simultaneously the morning after delivery, or having a vaccinator come to the facility and take the extra doses with her when she leaves the facility to go to the well-baby clinic, among others.

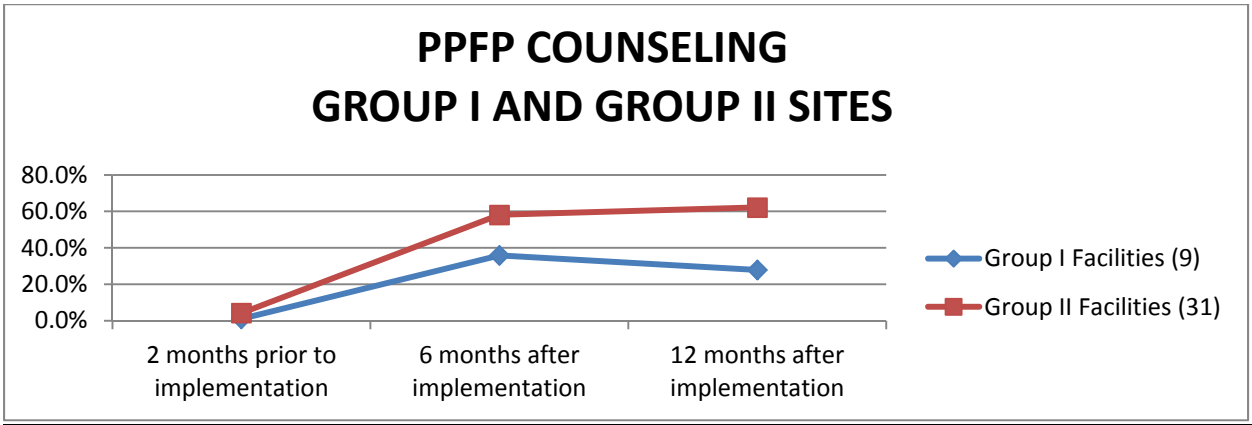


	2 months prior to implementation		6 months after implementation		12 months after implementation	
	GI	GII	GI	GII	GI	GII
# of deliveries at facility in which ENC was applied	84	754	129	1,945	135	1,924
Total # of women who delivered at the facility	185	2,525	157	2,799	177	2,761
Percent	45.4%	29.9%	82.2%	69.5%	76.3%	69.7%
Group I (GI): 9 Facilities; Group 2 (GII): 35 Facilities						

PPFP Counseling

Group I facilities increased the amount of PPFP taking place from 1% of women being counseled at baseline (January 2012) to 28% at endline (March 2013). The Group II facilities also showed a marked increase in PPFP counseling from 4% at baseline (April 2012) to 62% at endline (June 2013). The facilities made obvious progress in terms of PPFP counseling in just one year and were invested in ensuring all women leave the facility after a delivery having participated in family planning counseling with a provider.

Facilities also worked to ensure health staff consider documentation of the counseling sessions as a necessary part of their duties. Because no standardized system for documenting family planning counseling sessions existed, however, facilities have taken innovative steps to improve documentation of PPFP. Some used counter books for documentation while others added a column for PPFP counseling to the maternity register.



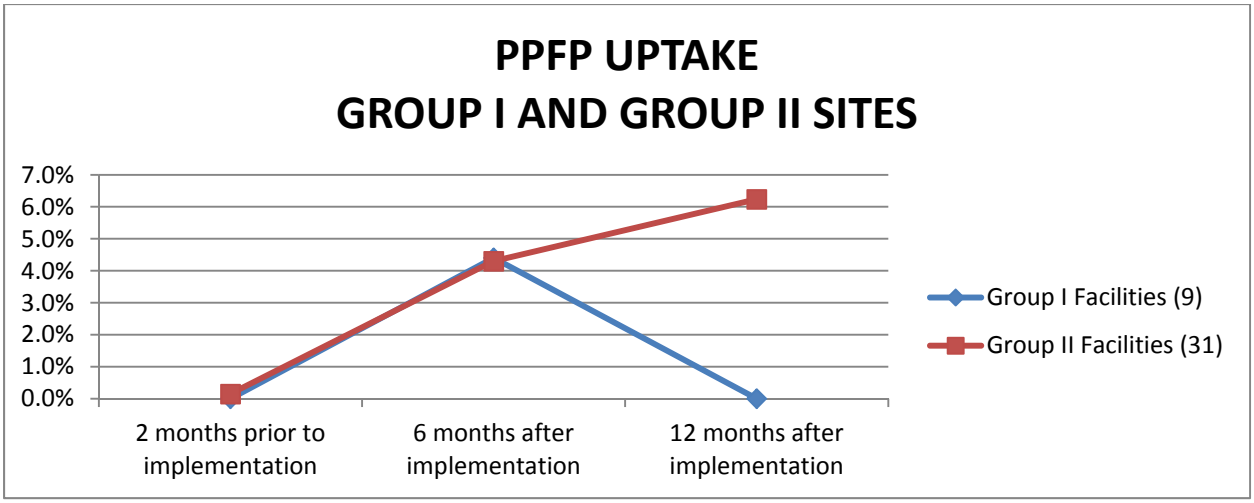
	2 months prior to implementation		6 months after implementation		12 months after implementation	
	GI	GII	GI	GII	GI	GII
# of PP clients counseled on FP methods	2	86	57	1,362	49	1,554
Total # of women who delivered at the facility	185	2,031	159	2,344	176	2,502
Percent	1.1%	4.2%	35.8%	58.1%	27.8%	62.1%
Group I (GI): 9 Facilities; Group 2 (GII): 31 Facilities						

PPFP Uptake

The results for PPFP uptake showed minimal increases for both Group I and Group II facilities. The increases are likely due to both improved documentation and knowledge, resulting from the initial learning sessions. The Group I facilities saw a slight increase from 0% to 4% in PPFP uptake from baseline to midline, and then a decline back to zero percent at endline. The Group II facilities recorded an increase of nearly zero percent to six percent in PPFP uptake from baseline to endline. All facilities are working to better inform providers about PPFP and strengthen their clinical skills in PPFP.

The PPFP uptake of 6% is low in comparison to PPFP interventions that focus mainly on PPIUD insertion in other countries. Most providers implementing the IC had not received training in PPIUD insertion, while the few who had been trained did not feel that they had the competence to offer the method and requested more practice. It's worth mentioning that this low uptake did not result from contraceptive stock-outs. Most facilities have access to IUDs, progestin-only pills, condoms, and have the skills for counseling women on LAM; rather, it is misperceptions about PPFP among clients and providers that lead to bias against offering these methods during the immediate postpartum period. Bias, coupled with providers' lack of skills in offering PPIUD and lack of documentation of the intention to use LAM, largely explains the low PPFP uptake.

Facilities worked to improve documentation of women counseled on lactational amenorrhea method (LAM). Providers did not document LAM because they expressed concern that even if a client exhibits intention to practice LAM, they cannot ensure that the client will continue practicing the method after being discharged from the facility. Facilities are also building providers' skills in IUD insertion, a skill that is particularly weak. And because women in Uganda are often reluctant to take a family planning method directly after delivery, facilities are working to institute family planning counseling during antenatal care sessions so that women have time to think about method choices and discuss family planning with their husbands before making a decision after delivery; the facility QI teams accept this approach of counseling during antenatal care as a best practice that needs to be expanded.



	2 months prior to implementation		6 months after implementation		12 months after implementation	
	GI	GII	GI	GII	GI	GII
# of PP clients who received P method	0	3	7	102	0	156
Total # of women who delivered at the facility	185	2,031	159	2,372	176	2,502
Percent	0.0%	.1%	4.4%	4.3%	0.0%	6.2%
Group I (GI): 9 Facilities; Group 2 (GII): 31 Facilities						

Summary

The results of this analysis indicate the positive impact of the IC approach: there have been marked improvements in four of the five indicators (partograph use, AMTSL, ENC, and PPFP counseling). However, many facilities struggle with sustaining improvements or are still working towards the desired 100% targets for these essential indicators. Facilities face particular difficulty with proper documentation and staff turnover, which they are actively addressing by immediately orienting new staff to the best practices upon their arrival at the health facilities. Facilities have also been challenged by stock-outs of essential medicines. Mentors and coaches have taught many staff how to order and purchase drugs, particularly Oxytocin. Facility teams are advocating to their district-level coaches and mentors, who, in turn, advocate to the national government for adequate drug supplies. Because facilities have to deal with a high case load of complicated deliveries that result from women arriving at health facilities, particularly hospitals, when they are in a critical condition, health care providers are therefore rushed in to save lives and have very little time to focus on applying standards of care and documenting their use. It is therefore important that the district QI teams have placed such a strong emphasis on the importance of adhering to clinical standards and have also encouraged stronger linkages with community health workers and village health teams who can help ensure women go to their antenatal care visits and arrive at the facility before their situation is dire.

It is expected that both Groups I and II will overcome their challenges and achieve close to their100% targets. Cross-facility learning during IC learning sessions will be particularly important to these goals. USAID has awarded STRIDES an extended stream of funding that runs through the end of 2014, which will allow the project to offer more technical assistance to the demonstration facilities, enhance cross-facility learning, and increase the overall sustainability of the IC.

Lessons Learned and Recommendations

- **Involve the district health team in coaching and mentoring visits for district ownership and sustainable uptake of the QI intervention.** This will also help improve facility engagement and motivation to implement planned activities.

- **Involve leadership and management of the facility in QI activities to help with problem-solving.** Facility managers influence resource allocation and can help motivate service providers by contributing to a supportive work environment where service providers' needs are met.

- **Integrate family planning provision during the immediate postpartum period by providing capacity-building support across all target facilities to address the high missed opportunity for access to family planning among women of reproductive age.** Despite the fact that providers are busy and still express some bias against family planning integration, family planning counseling and uptake improved in quantity and quality. However, the provision of LAM and postpartum IUDs, and documentation of their uptake needs to be strengthened by building providers' skills through routine coaching and mentoring. Facilities need immediate on-the-job training for postpartum IUD insertion and contraceptive provision during the immediate postpartum period, which could be supported by continued coaching and mentorship from STRIDES and the MOH coaches, particularly for monitoring family planning counseling and service provision. Facilitating resource persons within the facility and/or district to train service providers on-site in PPFP, particularly LAM and postpartum IUD insertion, can help build a critical mass of trained providers and thereby increase uptake of PPFP methods. Additionally, women should participate in routine family planning counseling, which starts during their antenatal care visits.

- **Engage QI teams to address stock-outs.** Stock-outs of maternal and child health supplies, including Uterotonics, Vitamin K, Tetracycline Eye Ointment, vaccines, and antibiotics, are common. QI teams and coaches have been trained to routinely monitor stock status. Shared experiences have led facilities to reallocate supplies from other facilities within the district to avoid future stock-outs, and some facilities prioritized purchase of those supplies within their budgets.

- **Link with community outreach programs, village health teams, and community health workers to improve quality.** Most QI issues have root causes in the community and cannot be managed without strong facility-community networks. QI teams need to address variables across the continuum of care (lower-level facilities and community) to prevent complications (prolonged labor and postpartum hemorrhage). E2A is exploring the possibility of building a community outreach QI component in two Group I districts and documenting the findings in an addendum to this brief.

Conclusion

Systematic approaches for scaling up best practices, such as the IC, can accelerate introduction of high-quality services. Programs can apply the IC to accelerate local capacity building, empowerment, and institutionalization. The IC can be introduced at any time during program implementation using existing resources and requiring minor modifications to existing approaches. E2A and STRIDES found that experience-sharing between QI teams on a quarterly basis encouraged problem-solving, proper planning, improved leadership, clinical, and QI skills. It was also apparent that the IC empowered the teams to explore simple and locally generated solutions rather than relying on central-level resources to address challenges at facilities.

The IC relies on on-site coaching and mentoring, and building technical capacity of various health worker cadres involved in patient care at different levels. Applying the IC increased the implementation of and adherence to evidence-based standards, and improved documentation of maternal and child health services in the target health facilities. Essential tools such as registers, QI journals, flow charts, and supervision were improved, which improved data use for decision-making and service quality.

Integrating immediate PPFP into maternal health services helps address a significant missed opportunity for offering women of reproductive age access to family planning services. To be effective, however, integration has to be supported by encouraging women to accept family planning services during antenatal care visits and building providers' skills in the provision of immediate PPFP (LAM, IUD, other methods).

Next Steps

For effective advocacy and scale-up of the selected best practices, the IC approach relies on results being disseminated 18 to 24 months after the IC has been introduced. STRIDES and E2A plan to do so by locally disseminating the IC findings during a national workshop that will be held in November 2014. Depending on the availability of resources, STRIDES might support the expansion of the IC to lower-level facilities and link with community outreach programs in the 10 districts. The expansion would be a formidable step to supporting the QI teams, linking the higher-level facilities with the lower-level facilities, and preventing complications across the continuum of care. The current district QI team leaders and supervisors could be a great resource during the expansion. The same clinical package and job aids used at higher-tier health centers can be applied in lower-level facilities with minor modifications to reflect provider capacity.

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