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The Use of Integrated Supportive Supervision (ISS) Visits to Strengthen Family Planning Service Delivery in Two Selected States of Nigeria

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Abstract

Efforts to expand access to contraception for healthy timing and spacing of pregnancies (HTSP) includes the engagement and capacity building for service providers. The quality of services being provided by SPs during integrated supportive supervision (ISS) visits has not been assessed. This study assessed the quality improvement of FP service delivery during ISS visits to secondary health facilities in 2 states of Nigeria. Twenty program managers competent on FP service delivery were drawn from each of the two states; and trained for 4 days on the use of ISS checklist to monitor quality of FP services. A 13-page ISS checklist developed by the FMoH, and field tested by Jhpiego in collaboration with other stakeholders was used to elicit data from 20 health facilities. Two Rounds of ISS were conducted between October 2014 and March 2015. Data was entered and analyzed using SPSS 17.0 version. FP new acceptors increased from 48.7% at 95% CI, 0.272-0.728 in Round-1 to 50.3% at 95%CI, and 0.272-0.728 in Round-2. Only 2.5% at 95% CI, 0.001-0.249 of the SDPs reported stock-out of FP commodities in Round-1 while none in Round-2. Stock-out of consumables reduced in-between rounds notably sterile gloves from 40.0% to 26.3% in Round-2; Examination gloves from 50.0% to 23.7%; Gauze swabs from 50.0% to 28.9%; Gaps still exist in number of SHFs reporting poor availability of infection prevention equipment. ISS is a key strategy that can help to reduce programming barriers and achieve desired objectives. Feedback in-between rounds was used by the SPs to plan for performance improvement.

Keywords: *Family planning, quality improvement, integrated supportive supervision, secondary health facilities*

Introduction

Contraceptive prevalence rate (CPR) in Nigeria is 15% for all methods although, the figures varied by states. It is 25.5% in Akwa Ibom and 1.3% in Zamfara (NDHS, 2013) and CPR for implants was only 0.4% in the 2013 NDHS for the country. Although, the current unmet need for family planning is reported to be 16% which is an improvement from the 20 reported in 2008, the figure remains unacceptably high. Various factors have been associated with the low CPR in Nigeria including high fertility preferences, ignorance, myths and misconceptions and lack of knowledge and skills of the service providers at service delivery points.

This informed the reason that Nigerian government at the FP2020 committed to achieve a contraceptive prevalence rate of **36% by 2018** (from mCPR was 9.8% in 2013); **Provide US $8.35 million annually over the next four years** in addition to the $3 million already committed to ensure that FP commodities and services are free: Work with the state and local governments to **secure complementary budgets for family planning** and reproductive health service delivery; and **Partner** with the private sector, civil society, traditional and religious institutions and development partners(FMOH, 2012). In order to accomplish this national aspiration, GON worked with stakeholders and developed LARCs scale-up strategy which identified six critical areas for immediate action. These include 1) Prevent disruptions in commodities supply to facilities; and provide consumables and required insertion kits to support service delivery 2) Client demand and utilization – increase awareness of the use of and availability of free FP commodities among health workers 3) Capital Sustainable financing mechanisms for distribution and supervision via state and

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federal support 4) strengthen LGA and state ownership of FP programs and finally 5) coordination through strengthening national and state-level program coordination for LARC scale-up and 6) capacity building – developed costed and phased national training implementation plan to increase health workers capacity in provision of LARCs; and strengthen supportive supervision and mentoring). Supportive supervision has been shown to demonstrate the potentials of a two-way communication channels whereby supervisors interact with those that they supervise. Furthermore, it serves as a problem-solving approach by providing the platform where supervisor and supervisee worked together to find solutions to challenges facing their activities and interventions; and through this approach supervisors mentor the supervisees (Marquez L; Kean L, 2002).

Objectives

This study assessed the quality improvement of FP service delivery during integrated supportive supervision visits to secondary health facilities in 2 states of Nigeria. It is part of the effort to ensure that Accelerated Scale of Implant (ASI) project which targets the rapid acceleration of access to women in Nigeria to increase the use of implants through quality implants services and capacity building were achieved. It is envisage that adding implants to the contraceptives mix will make many women have access to a full range of contraceptive methods and therefore be able to select the ones suited for their needs including implants which are very effective. The study assessed the compliance of the service providers to the use of the checklists in improving the quality of family planning service delivery during two rounds of supportive supervision in 20 selected secondary health facilities in the study areas.

Study methodology

Design

This supportive supervision was descriptive and consists of a cross-sectional pre- and post- design. The two major components of the study were carried out in the facilities in Akwa Ibom and Zamfara: It included facility assessment of characteristics such as infrastructure, supplies and equipment, staffing as well as services offered at the facility; (ii) Providers skills and knowledge assessment of family planning especially long acting reversible contraception. Twenty program managers competent on FP service delivery were drawn from each of the two states; and trained for 4 days on the use of Integrated Supportive Supervision checklist to monitor quality of FP services. A 13-page Integrated Supportive Supervision checklist developed by the FMoH, and field tested by Jhpiego in collaboration with other stakeholders was used to elicit data from 20 health facilities. Two Rounds of supervision were conducted between October 2014 and March 2015.

Study site and population

The study was conducted in Akwa Ibom and Zamfara states. The states were purposively selected for the implementation of the Accelerated Scale-up of Implants Project for their low implants contraceptive prevalence rate (CPR) at 0.7% and 0.1% respectively. Also the two states present the variation that exists in Nigerian geopolitical locations with Akwa Ibom in the South-South while Zamfara in the North West zone of Nigeria. Akwa Ibom state is a homogenous group of people with the same ancestry lineage; with landmass of 8,000 Sq. Kilometers. Climate is tropical with the wet season occurring between April and October while dry season between November and March each year. The state is predominately Christian community, mostly farmers, craftsmen and merchants with total of population of 3.9 million people (NPC, 2006). The overall Adult literacy rate is 75.1% with male rate at 79.7% while the female literacy rate is 70.2% (NBS, 2010). Akwa Ibom State has over forty-seven general hospitals with one tertiary hospital but only twenty-five provides family planning services. None of these facilities provide LARCs.

On the other hand, Zamfara state is predominately Islamic and agrarian population (including livestock production) and home to 3.2 million people (NPC, 2006). Zamfara state is reputed for its Rainy season from June to September while dry season occur between October and May each year. Overall adult literacy rate

is 26.2% while the rate for men (33.3%) is much higher than the female (18.8%) (NBS, 2010). Zamfara state has twenty-two general hospitals and two tertiary hospitals, only twenty of the facilities provide family planning and very few deliver LARCs. Forty (40) health facilities, 20 from each state were assessed out of which 3 are tertiary institutions and the remaining are secondary level health facilities. The health facilities were purposively selected after a rapid facility assessment based on existing provision of family planning services, existing space, availability of equipment and instruments; service providers that would be trained and client follow that would support the delivery of family planning services.

Intervention

The aspiration of the Government of Nigeria is capacity building. Government worked with her stakeholders and developed costed implementation plan which phased national training of at least 5,500 health workers across the thirty-six (36) states and Federal Capital Territory (FCT); and to increase health workers capacity in provision of LARCs; and strengthen supportive supervision and mentoring). ASI project worked in only two states of the Federation. First the project conducted clinic skills standardization for 20 national and state level trainers, who developed action plan and stepped down the training to 220 service providers (Medical doctors, nurses/midwives) from forty-three (43) General Hospitals and forty five Primary Health Care Centers. One hundred and eight (108) were trained in Akwa Ibom while one hundred and twelve (112) in Zamfara. Also, forty-four (44) service providers drawn from twenty hospitals in Zamfara and twenty-four in Akwa Ibom states were trained on Jhpiego's standard-based Management and Recognition approach for quality improvement of performance standard. Eight (8) program personnel drawn from State Ministries of health Akwa Ibom, Zamfara Federal and National Primary Health Care Development Agency (NPHCDA) and **fourteen (14)** high performing service providers from Akwa Ibom and Zamfara state hospitals were trained on supportive supervision.

Sample size

Twenty general hospitals were visited. Respondents for the integrated supportive supervision included health administrators and in-charge of different units and departments within the facility who could provide necessary information on availability of infrastructure, equipment, human resources and types of health care services the facilities were providing. Respondents for the knowledge assessment consisted of health care providers working specifically in the FP units of the selected facilities. They were also selected based on their readiness to participate in the assessment and/or were selected by the in-charge of the FP units after being trained by the project on Long Acting and Reversible Contraceptives (LARCs).

Data collection procedure

Twenty program managers from high performing service providers were drawn from each of the three senatorial zones in Akwa Ibom and Zamfara States of Nigeria based on competence and proficiency in the delivery of FP services. They were thereafter trained for four days on use of the Integrated Supportive Supervision (ISS) checklist to carry out process monitoring of the quality of Long Acting Reversible Contraceptive (LARCs) services in 20 facilities supported by the project, as well as knowledge and skills of the Service Providers. Two teams of three men per team were drawn from the pool of trained personnel in each state and they conducted the first round visiting twenty general hospitals. In the second four teams were constituted (two per state), and each team is made up of two trained personnel on Integrated Supportive Supervision. The teams visited each Service delivery point for one or two days (depending on size and volume of work at the Service Delivery Point) using a thirteen page Integrated Supportive Supervision checklist. The checklist was developed and field tested by Jhpiego in collaboration with FMoH and other stakeholders to monitor the availability, access, and quality of LARCs services, in the service delivery points. Two rounds of integrated supportive supervision were carried out between October 2014 and March 2015. Data was entered and analyzed using 17.0 version of Scientific Package for Social Science (SPSS). The results of each round of the visit were used by providers and project managers to plan for improvement of service delivery at the health facilities. Example, following the drop in skills on implant removal,

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refresher course on implant removal was organized for the service providers towards the end of the project when the life span of the inserted implant would have been due for removal.

Ethical approval was sought and received from the Ministry of Health in Akwa Ibom and Zamfara states, National Health Research Ethical Committee (NHREC) and the Institutional Review Board (IRB) of Johns Hopkins University in the United States. These ethical committees reviewed and approved the study protocol, data collection instruments and consent forms.

Data analysis

Data entry was done using the SPSS Inc, 11, Chicago software version 17.0. Descriptive statistics was used for the data analysis of the first and second round of visits to the health facilities. Analyses included percentages, means, Confidence intervals and P-values to determine statistical significant values.

Sociodemographic characteristic of providers

The background characteristic of the family planning service providers interviewed in the health facilities is presented in Table 2. The overall mean age of providers in both states was 44.6 (±8.6) years. Akwa-Ibom is 48.5 years and 40.7 years in Zamfara. While at least 8 out of ten service providers are 40 years and above in Akwa Ibom, only 5 out of ten service providers fall within that age range in Zamfara. Comparatively, in Akwa-Ibom, 86% of the service providers are at least 40 years old or above but in Zamfara, only 59.5% of the providers fall within that age range. A substantial proportion of the providers had midwifery training and experience.

In Akwa-Ibom, 95% at 95% CI, 0.904-0.949 of service providers are qualified nurse with midwifery training while in Zamfara, 79% at 95% CI, 0.639-0.832 of the service providers are either nurses with or without midwifery training. Majority 89% at 95% CI, 0.795-0.861 of the service providers from both states have worked with their qualification for 10 years or more. In Akwa-Ibom, 67% at 95% CI, 0.648-0.728 have worked in the FP clinic for 3 years or more while 76% at 95% CI, 0.060-0.942 in Zamfara had spent three or more years in FP clinic.

Table 2 shows the pattern of training received by family planning service providers in Akwa-Ibom and Zamfara. Overall, more than half of the FP clinic staff received training across all aspects of training considered at the round 2 in both states.

There is significant increase in the proportion of FP providers in Akwa Ibom (33.3% to 100%) who received training in the last two years. However, the percentage of providers who received technical update on FP and attended skilled-based course on implants at the end of the intervention is higher in Zamfara.

Skills and knowledge of providers to provide LARC

The average (score) of correct responses out of 15 questions related to provision of LARC among service provider in both states is presented in Figure 2. There is significant difference in the knowledge score between round-1 and round-2 for both states. Service providers in who previously scored an average of 4.79 out of a possible 15 LARC related question at round-1 and scored an average of 11.32 at round-2 in Akwa Ibom state.

Furthermore, the skills and knowledge of family planning providers were assessed based on specific variables. The results presented in Table 7 are based on several assessment questions. The result shows that service providers have significantly improved on their skills and knowledge about effectively providing family planning services to clients in both states at endline. In Akwa-Ibom, it was observed that almost all the improvements on specific skills and knowledge of FP service providers were significantly associated with the intervention. In Zamfara, noticeable improvements on skills and knowledge-related assessment questions were significant in seven out of the 15 questions assessed. This implies that by the end of intervention, the skills and knowledge of FP providers about the various family planning methods and conditions for provision and use improved, although with better outcome in Akwa Ibom.

Percentage increase in new FP method acceptance

New FP methods acceptance increased in round-1 from 48.7% at 95% CI, 0.272-0.728 to 50.3% at 95% CI, 0.272- 0.728 in round-2. Even though number of FP new method acceptors increased at rounds-1 and round-2. Findings, showed the increase was much higher by 1.6% at 95% CI, 0.001-0.249 in the round-2 of integrated supportive supervision intervention period when mentorship and supervision was provided to the service providers

Reduction in stock-out of commodities and consumables

Only 2.5% at 95% CI, 0.001-0.249 of the service delivery points reported stock-out of FP commodities at round-2 during the integrated supportive supervision. Gaps still exist in number of secondary health facilities reporting poor infection prevention 82.5% of the twenty service delivery points that were visited while inappropriate use of FP Balanced Counseling Strategy Cards among service providers was 31.5%.

Notable commodities that reduced in stock-outs and extent of reduction

Findings showed that sterile gloves reduced from 40.0% at 95% CI, 0.191-0.639 in round-1 to 26.3% at 95% CI, 0.087-0.491 in round-2. Examination gloves from 50.0% at 95% CI, 0.272-0.728 in round-1 to 23.7% at 95% CI, 0.087-0.491in round-2 while Gauze swabs dropped from 50.0% at 95% CI, 0.272-0.728 in round-1 to 28.9% at 95% CI, 0.178-0.421 in round-2 and cotton wool from 32.5% at 95% CI, 0.075-0.701in round-1 to 15.8% at 95% CI, 0.093-0.130 in round-2.

Discussions

This study presents the round-1 and round-2 supportive supervision visits to twenty secondary health facilities in two selected states of Nigeria – Akwa Ibom and Zamfara during the Accelerating Scale up It provides measures of change that occurred during the implementation of ASI on the quality improvement of performance standards in terms of utilization of implants by clients, skills and knowledge of service providers on LARC, as well as availability of consumables and equipment to provide family planning services in the facilities.

The round-2 findings shows an increase of 1.6% in FP method acceptors in the use of implants compared to round-1 results. This result is higher than the state overall percentage use of implants estimated by the Nigeria Demographic Health Survey 2013- 0.7% and 0.1% respectively for Akwa Ibom and Zamfara respectively (ICF Macro and NPC 2014). In the selected family planning units in Akwa-Ibom state, implants use increased significantly from 0% to 32% and 26% for Jadelle and implanon respectively while the usage of IUD declined by 13.8% at endline. In Zamfara state, implants use increased from 8.5% to 26.5% for Jadelle and 12.8% to 64.7% for implanon, while the use of injectables reduced significantly by 69.9%. Though the use of implants by clients in the two states increased at round-2, disparity exists in the proportion of the increase among the clients. Therefore visiting service providers during supportive supervision provides the impetus for joint problem-solving that would improve quality of service delivery as observed in this study. This is because the results in-between rounds are used to improve practice and services.

There was capacity building in some specific areas of family planning during the ASI program despite the fact that the health facilities are under the Federal Ministry of Health, who determines the staff strength in the two states. Both states experienced remarkable increase in the total number of staff trained in IUD and implants services in the family planning unit. However, Akwa-Ibom recorded the most significant increase in staff trained on family planning methods; 16% trained on implants at round-1which increased to 94% by round-2.

Service providers have significantly improved skills and knowledge on effective provision of family planning services and LARC to clients in the states by round-2. There is better outcomes in Akwa Ibom than Zamfara. Knowledge and practice of implants insertion/removal were significantly higher at round-2 than round-1. Skills and knowledge questions as per the checklist has 15 questions. In round-1 service

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providers could only answer 4 questions correctly, but this improved to 11 in round-2. This positive change varies by states: it was significant in Akwa-Ibom and Zamfara when supervisors give verbal feedback on job performance (15% and 19% increase respectively) and when supervisors participate in quality of care improvement activities (35% and 24% increase respectively).

There was significant decrease on consumable stock-outs. The notable consumable stock-outs occurred visibly in Examination gloves, gauze swabs, surgical iodine, sterile gloves and cotton wool. It was evident that visits of supervisors to the health facilities was provided the opportunity to discuss with the supervisees on how to maximize consumables for quality services. It also serves as a window for mentorship as supervisors demonstrated how service can be provided; and then work with the supervisees to develop action plan on how to improve quality of services within the time line agreed during the visit. Supervisees knowing when the supervisors will visit the next time will work hard to ensure that their performance goes more than the last round of visit. From the foregoing, it is very evident that ASI program supportive supervision in the two states (Akwa-Ibom and Zamfara) has improved the family planning services in terms of training of personnel, staff strength and skills development, accessibility and use of LARC. But the improvements in these facilities across the two states are not at the same pace.

Conclusion

The objective of the ASI was to improve the quality of family planning services in the supported facilities as well as scale-up the use of Long Acting Reversible Contraception (LARC) in the two states. To achieve its objective, the ASI Nigeria implemented hospital based interventions focusing on capacity building – training, supportive supervision and mentorship to improve the quality of family planning service delivery. The result presented here provided basis for assessing the quality of service improvement using integrate supportive supervision as key strategy for on-the-job-training, assessing availability of consumables, and jointly encouraging supervisors and supervisees to identify problems and finding solutions to them. The findings of the round-2 have revealed an increase in the use of implants, as well as improved skill and knowledge of service providers on effective provision of family planning services and LARC to clients in the states.

In this regard, training of the service providers and supporting them through supervision have been greatly instrumental for the positive changes observed in the use of LARC in the selected health facilities. To sustain the gains of this intervention, training and retraining of service providers as well as continuous supervision visits to the service providers is important. Government should be encouraged to take ownership of the intervention through continuous capacity building of the service providers and provision of supportive supervision visits. There should also be regular assessment of the routine statistics from the hospital record in order to maintain high patronage of the implants services.

Figures and tables

Table 1. Provider's background characteristics

Characteristics	**% (n=149)**
Age of providers	
Below 30	12.0
30-39	16.75
40-49	34.0
50+	37.3
Mean age (SD)	44.6 (8.6)
Medical Qualification	
CHEW	2.6
Nurse without midwifery training	18.6
Nurse with midwifery training	67..7

Midwife	9.7
Others	1.4
Years of working with qualification	
Less than 5 years	10.0
5-10 years	6.8
Above 10years	83.2
Years of working in FP clinic	
Less than 3 years	30.0
3-5 years	30.0
Above 5years	40.0

Table 2. Profile of service providers on Family planning training

Training pattern (multiple response)	(%)	
	Round-1 n=29	**Round-2 n=38**
Received technical update on FP	42.2	88.2
Attended a skill-based course on implants	28.6	91.8
Trained in the last 6 months on FP	37.5	95.3

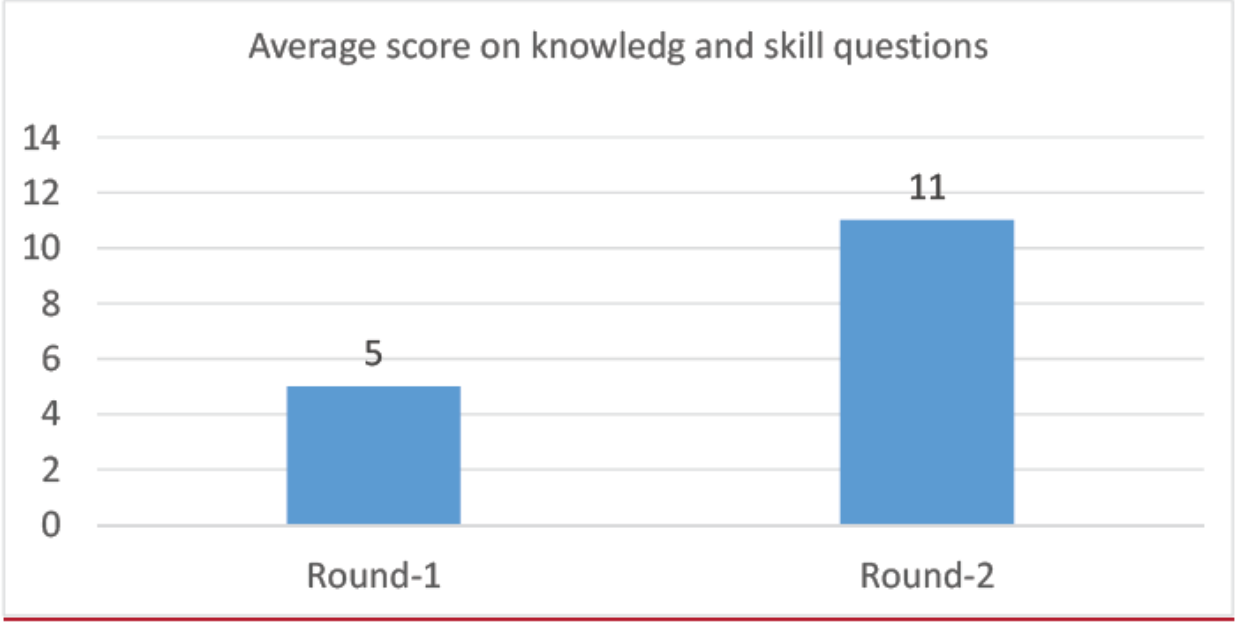

Figure 1. Skills and knowledge of providers on LARC

t = -9.75; p<0.05

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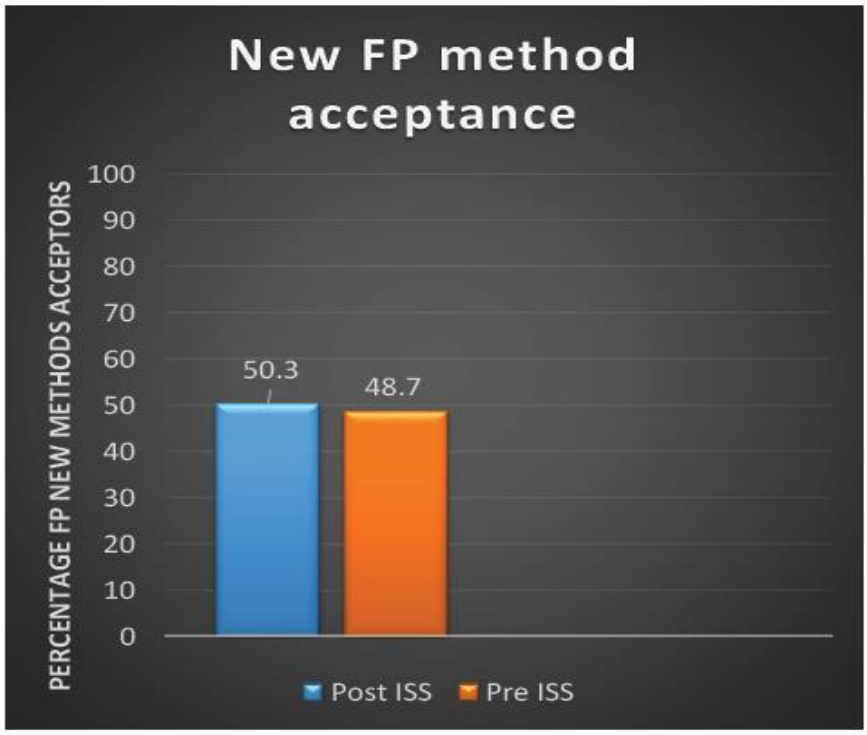

Figure-2. Percentage increase in new FP method acceptance

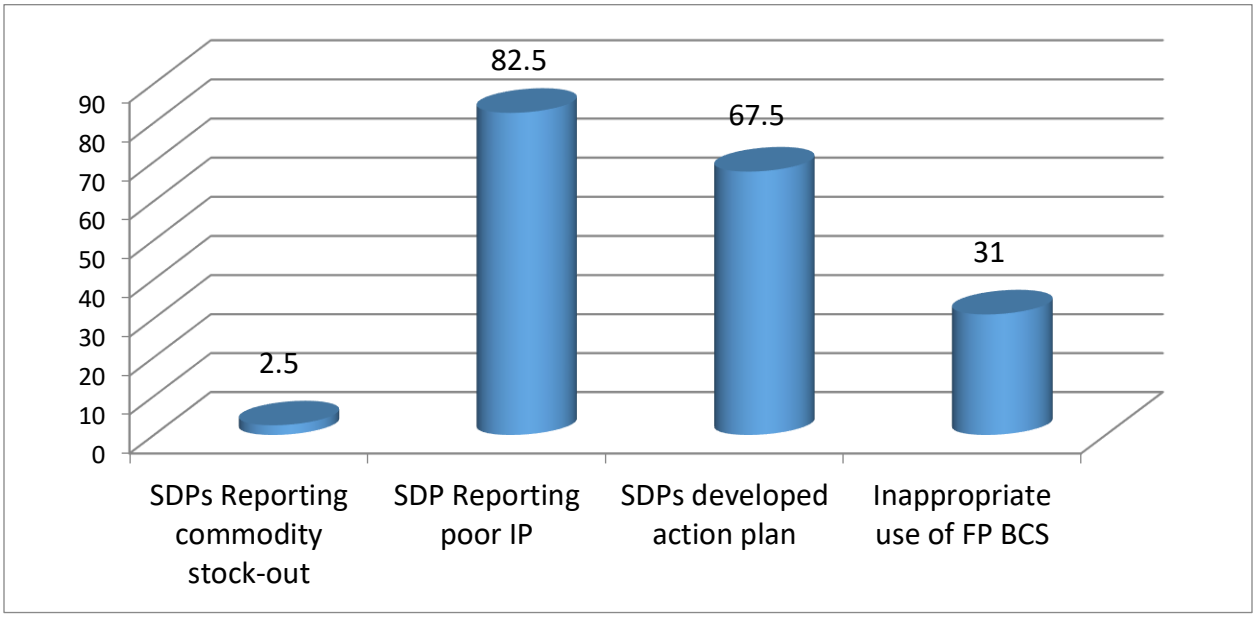

Figure 3. Service delivery points show reduction in stock-out of commodities and consumables but infection prevention (IP) and use of FP BCS are poor

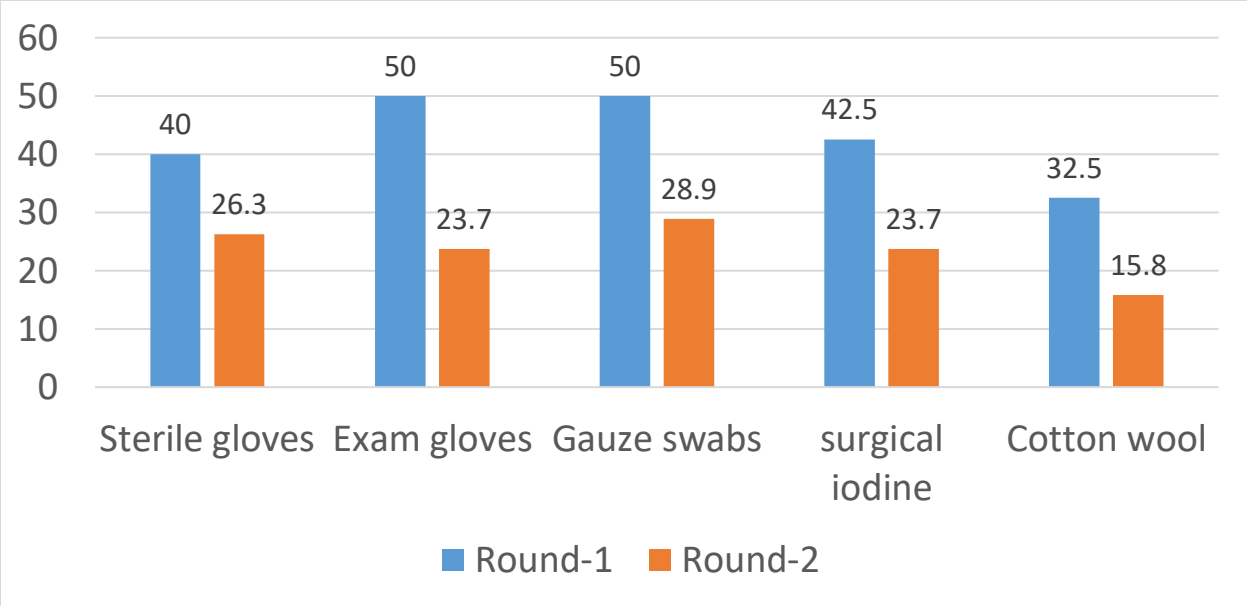

Figure 4. Notable commodities that reduced in stock-outs and extent of reduction

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