Chapter 2

Strategic choices in scaling up: introducing injectable contraception and improving quality of care in Viet Nam

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Summary

This chapter analyses the process of scaling up introduction of the injectable contraceptive depot-medroxyprogesterone acetate (DMPA) as part of a package of interventions to improve quality of care in the provision of all contraceptives in the Vietnamese family planning programme. After a strategic assessment of the need for contraceptive introduction and pilot testing of the interventions in three provinces, these interventions were scaled up to 21 of Viet Nam's 64 provinces. Although DMPA was widely introduced, going to scale did not fully achieve the gains in quality of care for all methods found in the pilot phase. Three interrelated variables affected this outcome: the degree of change required in the service delivery system, the pace of expansion, and available resources to support expansion. In this case, scaling up proceeded faster than was desirable, given the extensive changes entailed by the interventions and the limitations in resources. Before embarking on rapid expansion involving complex programmatic changes, planners of scaling-up strategies should carefully assess the balance between these three variables.

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Introduction

Introducing new contraceptive methods into health services often poses a fundamental dilemma. Provision of the new method is typically tested in a pilot setting in which a great deal of attention is paid to information for clients, counselling, and the technical and managerial aspects of service delivery. In contrast, other available contraceptive methods continue to be provided as they were before, often with inadequate quality of care. The Strategic Approach to Contraceptive Introduction,[1] sponsored by the World Health Organization (WHO), emphasizes the importance of ensuring quality of care in the provision of all available contraceptive methods when new ones are added to programmes (*1*). Viet Nam was one of the initial countries to implement the Strategic Approach. In the early 1990s, concerns arose about quality of care in the family planning programme in Viet Nam[2] and calls emerged for greater availability of a wider range of contraceptives (*2, 3*). Following a strategic assessment of the need for contraceptive introduction, a pilot project demonstrated that the injectable contraceptive depot-medroxyprogesterone acetate (DMPA) could be successfully introduced as part of a comprehensive effort to improve quality of care in the provision of all contraceptive methods.

This case-study describes the pilot project and its scaling up, showing how strategic choices influenced the extent to which success could be maintained during the process of expansion. Successful scaling up implies that key features of new practices tested and proven to be effective remain intact during expansion, because otherwise pilot results cannot be replicated. Literature on scaling up calls attention to the risk of losing the essential characteristics of interventions as they are expanded to new areas (*4*). This chapter chronicles how this risk was addressed in interventions designed to broaden contraceptive choice and quality of care in Viet Nam. Factors in the broader environment that influence strategic choices are highlighted as well. If programme managers understand the factors that affect scaling up, they can make decisions that increase the odds of achieving intended outcomes.

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[1] This was the precursor of the Strategic Approach to Strengthening Reproductive Health Policies and Programmes.

[2] The Vietnamese family planning programme involves two key ministries, the National Committee for Population and Family Planning (NCPFP, now known as Viet Nam Commission for Population, Family and Children, VCPFC) and the Ministry of Health as well as several mass organizations of which the Viet Nam Women's Union (VWU) is the most active. The NCPFP is responsible for the policy, financial and logistic aspects of the programme; the Ministry of Health is responsible for service delivery through its network of facilities in 64 provinces, 653 districts and almost 11 000 commune health centres; and VWU cadres promote family planning in communities.

The Vietnamese family planning programme was driven by an explicit policy to reduce population growth and a focus on modern, highly effective, and long-acting methods (*5*). Information provided to clients stressed the benefits of family planning for national development and "family happiness" (*6, 7*). The intrauterine device (IUD) dominated the method mix, accounting for 62% of contraceptive use. Natural methods, including withdrawal, represented 25% of use; female sterilization 6%; oral contraceptives 4%, and male methods (condom and vasectomy) 3%. Use of injectable contraceptives was negligible, and they were provided only in the private sector (*8*). Payments and incentives given to health workers and clients for providing or accepting the IUD or female sterilization called into question the extent of informed choice and clients' ability to freely choose a contraceptive method.

In 1993, programme managers proposed introducing the injectable contraceptive DMPA and the subdermal implant Norplant® into the national programme to broaden the method mix and thereby increase contraceptive prevalence. However, previous unsuccessful efforts to introduce new contraceptive methods raised concerns. Earlier introduction of oral contraceptives, which had taken place without a specific strategy or plan, had had minimal impact. Past small-scale trials of DMPA introduction found extremely high discontinuation rates, and evaluations noted the lack of adequate counselling concerning side-effects, provider misunderstanding of side-effects and their management, and poor follow-up of clients (*9–11*). A small-scale trial of Norplant® introduction also identified numerous difficulties in service delivery, including providers who had not been trained in removal, limited counselling, and insufficient coordination among government, nongovernmental organizations and donor agencies (*12*).

In light of these unsatisfactory outcomes, senior programme managers sought a more systematic approach to contraceptive introduction. When they learned about the recently developed Strategic Approach, they were eager to test this methodology to support introduction of DMPA and Norplant®. The approach had credibility, as it was espoused by a respected group of international agencies including WHO. Its phased process consisting of three stages – a strategic assessment, testing interventions and scaling up (*1, 13*) – would allow the national programme to move cautiously, without making a formal commitment to complete adoption or change from the outset. It also represented a means to avoid the difficulties experienced in earlier introductory efforts.

Application of the Strategic Approach began in late 1994 with a participatory strategic assessment of the need for contraceptive introduc-

tion, carried out by the Ministry of Health, the National Committee of Population and Family Planning (NCPFP) and the Viet Nam Women's Union (VWU), with technical assistance from several international partners. At a 1995 national dissemination workshop, participants reviewed and agreed with the assessment team's conclusions, which emphasized that priority should be given to improving quality of care in the provision of already available methods and that introduction of contraceptives currently not available within the public sector should be approached with caution. After intensive discussions, senior NCPFP and Ministry of Health officials and representatives from international partner agencies agreed that Norplant® should not be introduced at that time, because the service delivery system lacked the capacity to provide it with good quality of care. However, they approved the assessment team's suggestion to develop and test a systematic strategy for introducing DMPA as part of a broader effort to strengthen quality of care (*14*). The government was keenly interested in developing a strategy for introducing DMPA, an interest reinforced by the arrival of 160 000 donated doses of DMPA in the national warehouse. In light of this, the assessment team felt that a pilot project focusing solely on improving quality of care, without introducing DMPA, would have been rejected by the government. At the same time, the assessment experience had produced a consensus among key programme managers concerning the importance of improving quality of care in the provision of all contraceptive methods. Therefore a pilot project was proposed which would introduce DMPA while simultaneously addressing the overall quality of care.

The pilot project

The pilot project introducing DMPA as part of a package of interventions to improve quality of care for all contraceptive methods involved both service delivery interventions and research in three provinces. In the first year, 1996, activities focused on four districts selected from three provinces. In the second year, activities expanded to eight communes in each of the four districts. A five-person central team designed and managed the introductory study, with technical support from international partners. Central team members who had been involved in the strategic assessment included representatives from the Maternal and Child Health and Family Planning Department of the Ministry of Health, the Centre for Population Studies and Information of the NCPFP, and the VWU. At the provincial level a three-person team, composed of one member each from the health sector, the Provincial Committee for Population and Family Planning and the Provincial Women's Union, coordinated activities.

The project tested a range of managerial and service delivery modifications that dealt with weaknesses found during the strategic assessment in the six dimensions of quality of care outlined by Bruce (*15*).[3] DMPA was introduced into health facilities to broaden contraceptive choice. Training was designed to upgrade the technical competence of health workers and family planning field motivators. Training addressed knowledge and skills in counselling and information provision to support informed choice and use of the chosen method. It also covered the management of side-effects, infection control and other related areas of reproductive health. The principles and values of quality of care and reproductive rights framed these competencies. Information, education and communication (IEC) materials that emphasized voluntary choice of methods and how to use a chosen contraceptive were developed, tested and distributed to strengthen information given to current and potential clients. These materials replaced existing ones focused on the need for smaller families and the advantages of different contraceptive methods. Increased attention was given to ensuring client privacy at health facilities. The service mix was broadened through additional training and supervision to emphasize prevention and treatment of reproductive tract infections (RTIs) as well as post-abortion care and counselling.

New management and supervisory practices were developed and introduced. Management information tools – including client-held cards for all methods and a logbook for DMPA users, which recorded management of side-effects and dates of next visits – were tested to support follow-up and continuity mechanisms. In preparation for implementing these interventions, each pilot site conducted a situational analysis and used the findings to develop procedures to improve client flow, logistics management and infection control. Supervision was reoriented from inspection and a focus on achievement of demographic objectives to helping providers and managers direct their attention to quality of care and client-responsiveness. Teams of providers and managers at service delivery points were encouraged to seek the views of their clients and the community and to respond to them through action plans and follow-up activities. This was reinforced by routine collection of data on quality-of-care indicators.

Training was a key process for introducing the interventions. The skills of master trainers from the training institute of the Ministry of Health were strengthened; these trainers then trained provincial teams, who in turn trained providers and field motivators in the provinces and

[3] Informed choice, information giving, technical competence, client-provider relations, follow-up and an appropriate constellation of services.

districts. The master training team would later be available to support expansion of interventions. Training methodologies represented a further enhancement of practice in Viet Nam. Competency-based standards and principles of adult learning, wherein facilitators drew upon participants' own experiences and used interactive techniques, were quite different from the one-way teaching styles typically in use at the time. Supervisory visits, role modelling by central team members and administrative circulars reinforced the interventions. Mid-term and end-of-pilot-project dissemination workshops offered further learning opportunities. Articles about quality of care, the Strategic Approach and DMPA service delivery, published in the internal newsletters of the three agencies, helped to inform managers and providers about the interventions being tested.

Substantial effort was devoted to furthering trust, communication and collaboration between the Ministry of Health, the NCPFP and the VWU at the senior management, provincial and district levels, reinforcing the working relationships of these institutions developed during the strategic assessment. External technical advisers facilitated workshops on vision sharing, and routine meetings of the central and provincial teams contributed to the process of strengthening working relationships.

Research conducted during the pilot project included a quantitative study of DMPA acceptability, continuation and discontinuation as well as baseline and follow-up qualitative studies of client and provider perspectives and service delivery issues. Results from the first phase of qualitative studies were used to guide modifications in the interventions, especially changes in the service mix, counselling, IEC messages and the development of refresher training (*16*).

Results of the pilot phase

At all sites, many women showed an interest in DMPA and some began to use the method. Providing DMPA at the more accessible commune level in the second year increased adoption and facilitated follow-up and continuation. The one-year continuation rate for DMPA use in the pilot project areas was considerably higher than the rates experienced in earlier small trials in Viet Nam. Both the continuation rate and users' experience of side-effects were similar to international results. As women learned more about the method in their communities and its availability increased, the number of women choosing DMPA grew steadily. Preliminary study results suggested improvement in many of the dimensions of quality of care in the provision of all methods.

At the mid-term review workshop in March 1997, staff of the agencies involved in the project and representatives of donor and other partner organizations came together to analyse experiences from the first year of activity. The evidence convinced central team members that this systematic approach to introduction was valuable because it resulted in higher continuation rates for DMPA and a diversification of the method mix. They also saw that it benefited women. However, managers in the Ministry and the NCPFP who had not been involved in the pilot project expressed concerns that the testing was taking too much time and questioned the need for the full package of interventions. They recommended rapidly expanding introduction of DMPA, without all the other pilot interventions and without waiting until the two-year pilot project was over. Central team members and external technical advisers did not concur: they argued that rapid expansion of DMPA introduction, without the accompanying service delivery and management interventions, would not reproduce the broader improvements in quality of care found during the first year of the pilot project.

Shortly after the mid-term review, decision-makers in the NCPFP chose to proceed with only those interventions required to introduce DMPA in 11 additional provinces (hereafter called the "DMPA-only provinces"). They adapted and applied some of the principles and practices tested in the pilot project. For example, introduction of DMPA was phased, with activities beginning at the district level in only one district in each province. Introduction was later extended to a subset of communes in those districts. Site selection took into account the capacity of the facilities, staff and supervisors to support DMPA introduction with appropriate quality of care. The training curricula, IEC materials and management tools for DMPA, developed in the pilot project, were also employed. However, the range of interventions to improve broader quality of care in the provision of other contraceptives was not replicated.

At the final pilot project dissemination workshop in August 1998, participants reviewed the evidence from the pilot phase. User perspective and service delivery studies suggested that many dimensions of quality of care in the provision of all methods improved in the pilot sites. Some aspects of infection control were better, providers' knowledge of contraceptive methods increased and provider bias diminished. Improvements were also seen in counselling, provision of information to clients and client–provider relations. For example, providers paid more attention to clients' privacy and showed greater respect for clients' wishes. Abortion clients were more likely to receive post-abortion contraception. Provincial and district programme

managers, family planning motivators and community members demonstrated greater support for the concept of informed choice based on balanced information and counselling. Gaps remained, however, particularly in the quality of counselling for methods other than DMPA and for other related reproductive health services such as abortion care and the management of RTIs (*16*).

At the workshop, case-studies compared the experiences of the three pilot project provinces and the 11 DMPA-only provinces. Workshop participants concluded that the more comprehensive package of interventions tested in the pilot project yielded better results than the modifications implemented in the DMPA-only provinces. DMPA continuation was greater, the management of side-effects was better, and the quality of care in the delivery of all methods was superior. Based on this review, participants recommended that DMPA should be more widely introduced using the comprehensive intervention package. However, this introduction should proceed in a careful, phased manner within selected districts that met minimum standards regarding their capacity to provide an acceptable level of quality in service delivery. This set the stage for developing the next phase, which would be scaling up interventions tested in the pilot project.

Scaling up

Following the end-of-project workshop, an independent high-level committee appointed by the Ministry of Health further reviewed the evidence from the strategic assessment and pilot project, and recommended scaling up the principles and practices used in the pilot project. The central team prepared a proposal to introduce the comprehensive package of interventions in 21 of the 64 provinces (including the three of the pilot project) between January 1999 and June 2001. Though some individuals expressed concerns about the ambitiousness of the initial selection of 21 provinces, this large number was chosen for scaling up innovations within a period of less than two years because each had ongoing external donor support for family planning activities which resulted in both heightened interest in DMPA introduction and efforts to improve quality of care. There was an expectation that financial resources would be available to support the necessary programmatic activities.

Figure 2.1 shows the design of the scaling-up process in terms of the framework proposed by Simmons and Shiffman in Chapter 1. The innovation was the full package of interventions tested in the pilot project. The resource team consisted of the central team, with limited support from external advisers. External technical assistance was re-

duced to about 15% of that available in the pilot phase. In essence, the central team became the resource team – the primary source of guidance for scaling up. The user organization included the managers and staff at national, provincial, district and commune levels in the family planning programme. The scaling-up strategy involved implementing the full range of activities to support the introduction of the innovation and addressed both horizontal scaling up (replication of the innovation in provinces, districts and communes) and vertical scaling up (policy initiatives to institutionalize the innovation). Funding to support implementation at the district and commune levels came largely from ongoing international donor support to family planning activities[4] and from the regular budget of the national government.

A modular tool kit (Table 2.1) was a key component of the scaling-up strategy, serving as a guide for adapting and implementing the innovation. It included criteria for selecting sites and sample programme support materials. Consistent with the central government's practice of issuing guidelines and policy edicts to lower levels, the provinces selected for expansion were given the tool kit with the expectation that it would be closely followed, although with local adaptation. The central team then held workshops for the 21 provincial teams on how to use the tool kit. Each provincial team included representatives of the provincial health and family planning sectors and the Provincial Women's Union. Bringing together managers from these three institutions for a workshop was an unusual but constructive experience. Supervision and mentoring by the central team further supported the scaling-up process in the provinces. Because interventions in the pilot project had already been tested, the government saw scaling up as part of routine programme operations with no need for formal research and evaluation. Policy initiatives to institutionalize pilot project innovations included review and modification of national standards for all available contraceptive methods, and development and distribution of policy briefs for programme managers synthesizing lessons learned. Central team members continued to publish articles about the innovation. To develop the Vietnamese research community as a potential advocate for quality of care, the resource team organized a workshop for social scientists in the field of family planning. The objective was to strengthen their capacity to undertake studies on user perspectives and service delivery, as most previous social science research in reproductive health had focused predominantly on the demographic aspects of the population policy.

[4] WHO, the United Nations Population Fund (UNFPA) and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ).

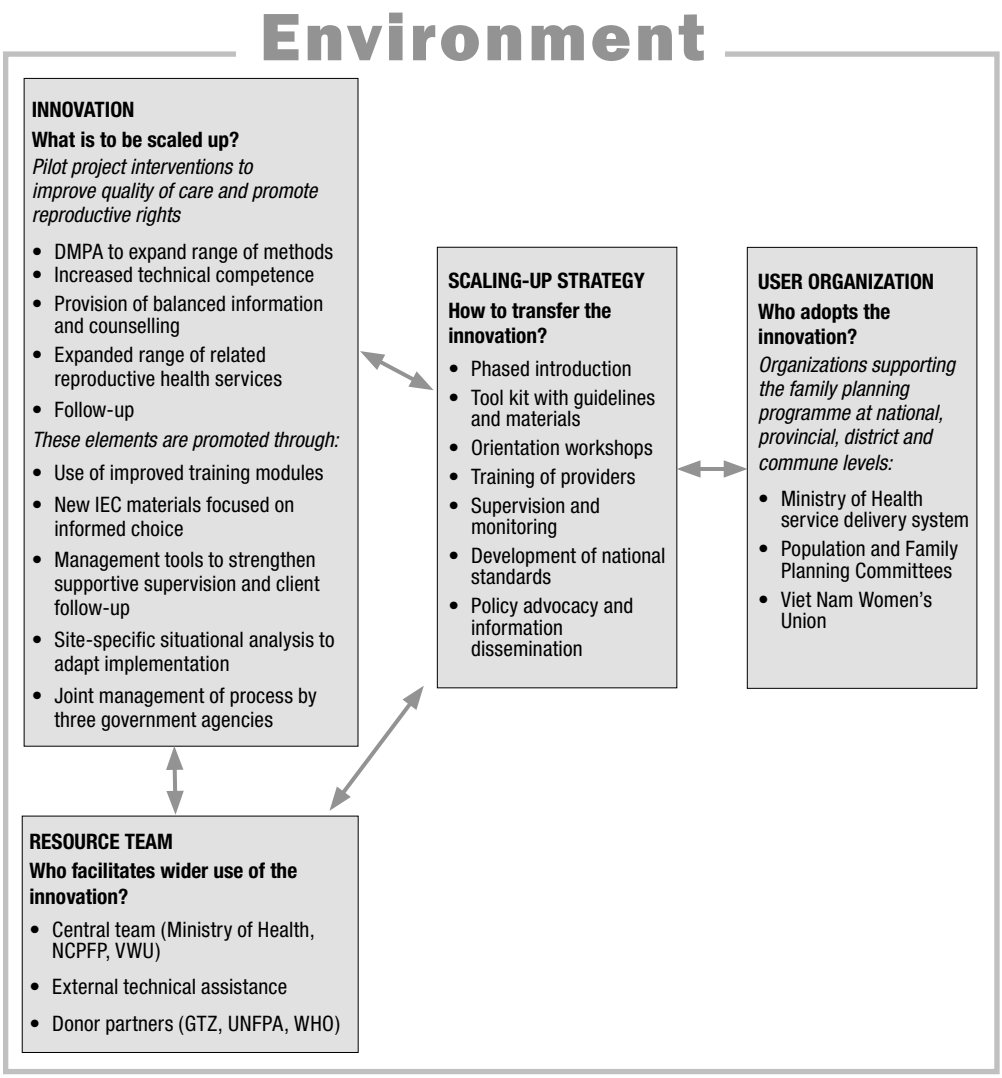

Figure 2.1 Design of the scaling-up process in Viet Nam

Outcomes of the scaling-up process

Before the pilot project, DMPA was not available in the public sector. At the end of the scaling-up phase in June 2001, about 2000 women had voluntarily adopted DMPA as their method of contraception, with a mean continuation rate of 50% at one year, similar to international experiences. Since then, scaling up of the innovation has continued as part of the government's routine programme. The NCPFP and the Ministry of Health now require provinces to submit an annual plan

detailing the continuing process for DMPA introduction. The plan must include arrangements for training and logistics, assessment of the capacity of the facilities to support quality of care and other aspects detailed in the tool kit. An approved plan then receives funding from the central level, supplemented by resources from the provincial budget. By 2002, all 64 provinces had begun the process of introducing DMPA. Subsequently, it became available in half of the districts and communes in Viet Nam. In 2002, national survey data revealed that DMPA accounted for an estimated 2% of modern contraceptive method use, up from 0% in 1996. The overall method mix was also somewhat more balanced: IUD use declined to 56% (from 62% in 1993), oral contraceptive use increased to 10% (from less than 4%), and male methods (condoms and vasectomy) accounted for 9% (up from 3%) of modern method use (*17*).

Steps in modular tool kit for scaling up	
1. Establish task force	8. Management information systems
2. Inform stakeholders	9. Supportive supervision
3. Situational analysis and action plan	10. Community support for quality of care
4. Action plans for quality of care	11. Facility requirements for quality of care
5. Plan for training	12. Accreditation process
6. IEC for quality of care	13. Monitoring for quality of care
7. Logistics for quality of care	14. Continuous quality improvement
Each step contains information on: ▸ Rationale ▸ Methodology ▸ Illustrations of previous experience in Viet Nam ▸ Examples of materials, tools and activities ▸ Advice on adapting the materials to local conditions	

Table 2.1 Contents of the modular tool kit for scaling up

Because the scaling-up process did not include a formal evaluation component, insights into the implementation and outcomes in other dimensions of quality of care come from routine service data and observations made by facilitators and central team members during supervision. Many principles and practices from the tool kit were implemented. For example, provincial and district teams used criteria in the tool kit to identify sites for scaling up. They phased the expansion process by typically choosing only two districts in each province; within each of these, they selected for start-up activities a few commune health centres that met minimum standards for quality of care. Provinces quickly adopted the logbook for DMPA users, and some used the client-held cards for all methods. Supportive supervision gained ground: provincial managers described how they discussed service implementation and problem-solving with providers, instead of looking exclusively at achievement of demographic targets. Training sessions utilized the competency-based, participatory, model training curriculum and facilitators' guides in the tool kit, and the new criteria for selection of trainers were followed. There was also evidence of an increase in client orientation. For example, some service providers asked that training and services place more emphasis on prevention and care of RTIs and HIV/AIDS, as well as on adolescent reproductive health, reflecting client and community demands. More IEC materials became available, and providers demonstrated greater understanding of the need to provide information and counselling to clients.

Despite these advances, improvement in the quality of care in provision of all contraceptive methods was less than that found during the evaluation of the pilot project. In general, training, counselling, IEC, management of side-effects, infection control and client follow-up related to DMPA provision were better than for other methods. Tool kit components were sometimes applied only to the delivery of DMPA. For example, some provincial training teams used the parts of modules that focused on this method and did not incorporate sessions that dealt with informed choice and quality of care. In some sites, IEC materials were provided for DMPA but not for other methods. Systems to monitor quality-of-care indicators were not fully implemented. The collaboration among the NCPFP, the Ministry of Health and the VWU that occurred during the pilot project was not in evidence in all provinces, and in many, the VWU was often not fully involved as a partner in scaling up. Similarly, in many districts and communes, field motivators did not receive training and thus continued to encourage long-acting contraceptives and did not engage the community in identifying needed improvements in quality of care.

Other related outcomes

Satisfied with their first experience implementing the Strategic Approach, the government decided to apply the methodology to abortion care. Following a strategic assessment in May 1997 (*18*), a pilot project to test quality-of-care interventions for comprehensive abortion care was put in place in two national hospitals, and activities are gradually being expanded to provincial hospitals. This programme gives evidence of the government's appreciation of a phased approach to introducing service delivery innovations.

The Ordinance on Population issued in 2004 demonstrates an increasing concern for quality of care in the family planning programme. This policy emphasizes the right of individuals to exercise choice of contraceptives, gives prominence to quality family planning services, counselling and improved access to information, and explicitly prohibits "preventing or forcing the utilization of family planning practices" (*19*). The recent removal of incentives formerly given to women who accepted the IUD provides further evidence of the national commitment to freedom of choice. Without a doubt, international partners and national advocates working on other initiatives have played an important part in these changes. In all likelihood, the rapid decrease in fertility among Vietnamese women – from a total fertility rate of 3.8 in 1985 to 2.2 in 2001 (*17*) – also reduced pressure on the government to pursue demographic targets and enabled the family planning programme to increase its focus on quality of care. Nevertheless, these changes represent remarkable policy shifts and significant advances for reproductive rights.

Discussion

In the course of the interventions described above, DMPA was introduced into the family planning programme in 21 provinces and its availability has since expanded to all 64 provinces. However, quality-of-care innovations related to the full range of contraceptive methods were not consistently implemented during scaling up. Reflecting on the reasons for such partial success brings to the fore three key interrelated variables that must be considered when planning and implementing strategies for scaling up: the degree of change that the innovation implies for the user organization; the pace of expansion; and the amount of resources available. Ideally, decisions about these variables are made so that there is congruence or balance among them; for example, the resources available must match the degree of change and the pace of expansion. However, these choices are often shaped by the environmental context (as depicted in Figure 2.2) and thus achieving

balance may be difficult (*20*). As this case-study illustrates, when the three variables are out of balance, it results in trade-offs in the outcomes achieved.

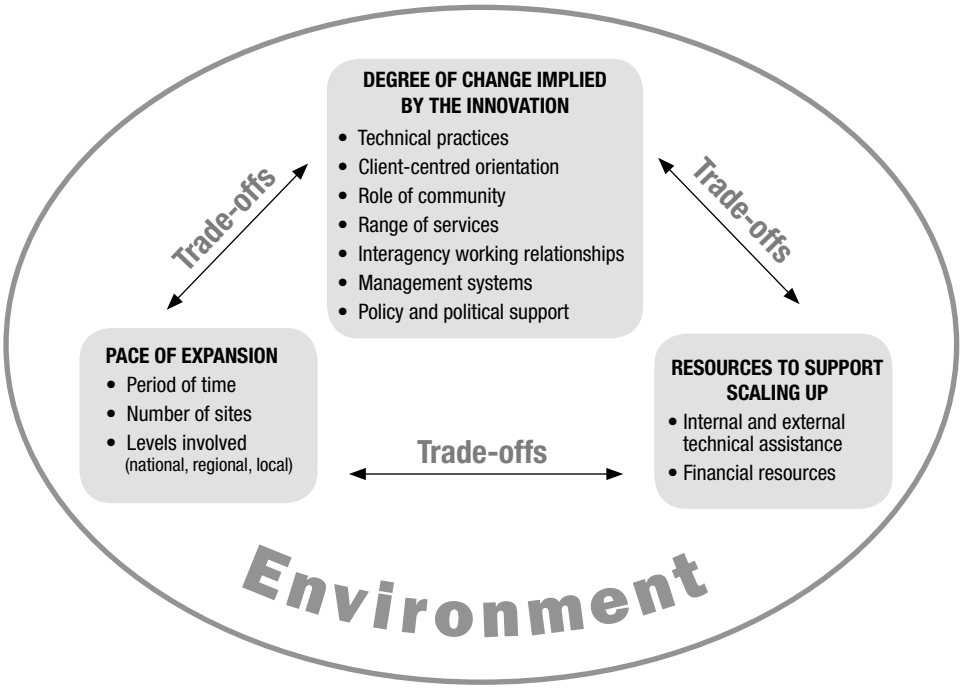

Figure 2.2 Strategic choices in scaling up: balance and trade-offs

The degree of change implied by the innovation

The innovation tested in the pilot project was a complex package of interventions aimed at improving the quality of care in family planning services. Full implementation called for much more than increasing provider knowledge and skills related to a particular technical issue: it required stronger programme and managerial capacities to support changes and a system-wide reorientation towards a client-centred approach. This new orientation involved transforming a pattern of client–provider interactions characterized by little counselling and a lack of informed choice into one of active, respectful exchanges. Providers were expected to offer balanced information, listen to clients' concerns, offer individually tailored guidance and be motivated to take the time to do so. In Viet Nam, however, prevailing beliefs among providers

and managers held that women did not want a lot of information about contraceptives and choice of method was considered the domain of medical providers. Provider incentives to encourage use of long-acting methods and community mobilization to reinforce the two-child policy persisted. Information given to clients generally centred on the advantages of certain methods and the importance of family planning. A client-centred orientation called for community participation in shaping service delivery, but community voices were seen as having little relevance for what was viewed as a strictly medical concern. Thus, the new emphasis on quality of care required major programme and provider reorientation. Linking family planning services with RTI prevention and treatment and post-abortion care was a novelty in a programme focused on demographic objectives. Furthermore, the Ministry of Health, the NCPFP and the VWU were not accustomed to working in close partnership at the provincial, district and commune levels.

In contrast, the technological aspects of introducing DMPA did not demand the same degree of change. This new technology was more directly in line with the priorities of the family planning programme, which gave precedence to achieving demographic goals through increased contraceptive prevalence and use of highly effective contraceptive methods. Programme leadership had high expectations about the impact that DMPA would make on increasing contraceptive prevalence. The provision of DMPA also benefited from being a tangible, readily observable innovation, and use of the method could be measured through routine service statistics, unlike elements of quality of care such as client satisfaction and informed choice. Furthermore, injections have a strong positive cultural value for both providers and community members in Viet Nam.

In sum, the distance between the existing state of family planning services and the required change inherent in the package of interventions was large. Breaking with established norms and practices and bringing about client-centred services and policies implied a high degree of change in a family planning programme characterized by a weak capacity to provide services with good quality of care. Even in strong health systems, getting health providers to modify minor elements of routine practice is a major challenge (*21*).

Pace of expansion

There was a strong desire among national-level policy-makers to scale up as rapidly as possible. Family planning programme authorities in many provinces were beginning to request DMPA introduction,

and national officials were eager to respond. The presence of DMPA supplies in the national warehouse reinforced this demand. In addition, members of the donor community wanted to incorporate DMPA into their projects and some were not convinced of the value of waiting for lessons to be learned from scaling up; prevailing international wisdom at the time maintained that provision of DMPA was not a complicated task. Although the resource team realized that a slower pace (scaling up initially in fewer provinces over a longer period of time) would be preferable, they felt it was more important to grasp the window of opportunity of government and donor interest in the introduction of DMPA and maintain the linkages between DMPA introduction and improvements in quality of care for all methods. In the interests of remaining engaged in the policy and programme strengthening process, scaling up proceeded at a relatively rapid pace. This strategic choice resulted in a trade-off: DMPA was made more widely available in a shorter period of time, but without all of the potential improvements in quality of care for all methods. In retrospect, and as the international literature and experience suggest, fuller replication of the package of interventions in 21 provinces might have been feasible with a more gradual process because of the extensive modifications in service delivery entailed in the innovation (Chapter 1).

Resources to support scaling up

As described earlier, resources for technical support were decreased as expansion proceeded. This choice was not a result of limited donor funding. Continuing the high degree of national ownership that had characterized the application of the Strategic Approach throughout the assessment and pilot project was considered critical for sustainable integration of the innovation into routine service delivery. At that time, the rationale held that once an innovation had been successfully tested in a pilot project, large amounts of outside support and funding would inhibit the potential for lasting change. Thus a decision was made to depend primarily on the five-person national-level resource team for provision of technical assistance and to rely on existing financial resources for implementation. In addition, the government was satisfied that the pilot project had adequately demonstrated the feasibility of implementing the package of interventions. Large-scale integration of the innovation into programme operations was considered a straightforward process.

Unexpected developments inevitably occur when working with public sector bureaucracies. Just before interventions began to be scaled up, three of the original five members of the national resource team left their positions or retired. The three new team members did

not have the benefit of experience with the strategic assessment and pilot project, and the resulting understanding about the importance of interventions to improve quality of care. This reduced the resource team's capacity to support the scaling up. Moreover, the team was charged with sizeable tasks that were added to their routine work: developing and producing the tool kit, conducting orientation workshops and supervising training for 21 provinces, providing ongoing support and guidance to the process, documenting experiences and assisting in development of technical standards for all contraceptive methods.

In hindsight, the choice to decrease both the human and financial resources available to support scaling up implied a trade-off with the degree of change that could be achieved. The extensive organizational and cultural changes needed on the part of the health services were more than the resource team could support and facilitate given the rapid pace of expansion. Producing the transformation implied by the innovation, particularly at the relatively rapid pace dictated by the policy window, would have called for a massive effort on the part of a sizeable and well-equipped resource team (see Chapter 1).

Balance and trade-offs

The strategic choices made regarding any one of the three variables – the pace of expansion, resources to support scaling up, and the complexity of the innovation – affect the other two and determine the success in maintaining intact the essential features of the innovation during the process of going to scale.

The compromised decision to pursue a relatively rapid pace of expansion brought some benefit (availability of an additional contraceptive method) to more women than could have been reached with a slower pace. However, a slower pace would have had the potential to bring greater benefit (improved quality of care for all methods) to fewer people. Alternatively, the rapid pace of expansion could perhaps have been supported by a larger and more experienced resource team, which might have been able to advocate for and promote all the changes implied by the innovation. When the divergence between the nature of the innovation and the characteristics and prevailing practices of the user organization is great, full implementation of the innovation may not be possible without either a slow pace or substantial resources to facilitate its integration into routine service delivery.

Conclusion

In designing and implementing strategies for scaling up tested innovations, tensions will inevitably arise among three critical

variables: the degree of change, the pace of expansion, and the resources required to achieve the desired change. Planners and implementers need to weigh the alternatives carefully and continuously reassess the implications of the trade-offs among these three variables.

Efforts to meet reproductive health needs will almost always encounter the imperative to expand innovations rapidly in order to reach the greatest number of people in the shortest possible time, given available financial resources. The potential of improved services and technologies to maximize health benefits and save lives, however, may obscure the degree of change implied by these interventions – changes in organizational culture, in managerial and technical systems, in clients and communities who need the interventions, and in the broader environment. At the same time, scaling up generally takes place in a context of constrained resources, characterized not only by limited finances but, more importantly, by weak public sector health systems with bureaucracies that are slow to adopt innovation and have few staff members to support and guide the introduction of large-scale changes.

Before undertaking to scale up innovations involving complex changes, planners and implementers would be wise to ask the following questions: What are the risks involved in moving quickly? Will a rapid pace of expansion potentially overwhelm a weak bureaucratic system? How far-reaching are the changes entailed in introducing the innovations? Are expectations so high that they are beyond existing capacities of the resource and user system? How will the capacity to manage the changes be strengthened? Is there a capacity-building plan in place and are the necessary resources committed? Is there a system to monitor and evaluate the scaling-up process? Once a set of innovations has been tested, scaling-up practitioners must reflect upon the relative risks and benefits of a more rapid versus a slower process, given the resources available to support expansion.

Although trade-offs may be unavoidable, discerning and understanding the multiple environmental factors that can affect the success of scaling up is equally important when making choices that seek to balance the degree of change implied by the innovation, the pace of expansion, and the amount of resources to support the change.

The case-study from Viet Nam provides a useful illustration of the importance of achieving an appropriate balance among the three key variables. Given the environmental circumstances that mandated a rapid pace of expansion and the large degree of change represented by the innovations tested in the pilot phase, there was a need for much greater human and financial resources to be devoted to support the development of the institutional capacity. In hindsight, the chal-

lenges of making major changes in how programmes are implemented and – even more important – changing the attitudes and practices of individual providers were greater than the resources devoted to the task. Although much was achieved in Viet Nam, the experience shows how critical it is to devote sufficient resources to building institutional capacity to support the process of scaling up an innovation. The lessons learned can help guide future efforts to scale up innovative pilot projects serving the reproductive health needs of people in Viet Nam and elsewhere.

Acknowledgements

We wish to thank the many individuals, who participated in the various activities described in this paper, for their valuable contributions. We also acknowledge funding for the implementation of the Strategic Approach in Viet Nam from the Department of Reproductive Health and Research, WHO, together with the UNFPA and GTZ offices in Hanoi.

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