Chapter 4

Expanding contraceptive choice and improving quality of care in Zambia's Copperbelt: moving from pilot projects to regional programmes

John P. Skibiak[a], *Peter Mijere*[b], *Mary Zama*[c]

Summary

This case-study explores the programmatic challenges of moving from pilot interventions to regional programmes. It documents the history of an initiative to scale up reproductive health interventions, developed and tested between 1996 and 2000 in Zambia's Copperbelt Province. The interventions included an expansion of the range of contraceptive methods available at health facilities, the development of innovative training approaches for health-care workers, and the testing of strategies to reach out to communities. This chapter highlights the challenges facing programme designers as they must decide which elements of a pilot study to scale up, the structures most appropriate for managing the process, and the pace and breadth of the expansion effort. Finally, it provides a conceptual framework to guide the scaling-up process and to weigh the potential trade-offs between increasing scale and the need to maintain quality, local values, local relevance and sustainability.

---

[a] John Skibiak, an anthropologist, was Director of the Population Council's Expanding Contraceptive Choice (ECC) programme in Africa. He was a member of the Zambia Contraceptive Needs Assessment team in 1995 and technical adviser to the ECC Pilot Study and Pilots to Regional Programmes (PRP) initiative described in this study.

[b] Peter Mijere is a public health physician and Deputy Chief of Party for SHARE, a USAID-funded initiative to address HIV/AIDS in Zambia. During his tenure as Director of the Copperbelt Provincial Office (2000–2004) he had management responsibility for the PRP initiative.

[c] Mary Zama, a public health nurse, is Consultant to the Population Council. She was Project Manager of the ECC Pilot Study from 1996 to 2001 and continued in that position throughout the PRP initiative. She resides in the Copperbelt and continues to manage a host of interventions designed to expand contraceptive choice and improve quality of care.

Introduction

Pilots to Regional Programmes (PRP) is the name of a broad-based initiative for bringing to scale a series of reproductive health interventions, which had been developed and tested between 1996 and 2000 in Zambia's Copperbelt Province. Launched in 2002, PRP aims to expand contraceptive choice and increase the availability of quality reproductive health services, especially family planning, in all eight of the Copperbelt's rural and peri-urban districts. It also seeks to field-test a model for scaling up reproductive health interventions, originally implemented on a pilot basis. The model employs a three-phased process in which districts adhere to a common set of quality standards while maintaining the flexibility to decide, based on local needs and conditions, the most appropriate means of achieving these standards and the relative investment they intend to make in doing so.

This case-study explores the programmatic challenges of moving from pilot study to broad-based initiative. It documents the history of the initiative, more specifically the circumstances leading to its development, the scaling up of activities and its achievements. It also describes a conceptual framework that guided the scaling-up process, while at the same time weighing the potential trade-offs between increasing scale and the need to maintain quality, local values, local relevance and sustainability.

From strategic assessment to pilot study

In 1995, the Zambia Ministry of Health sponsored a strategic assessment of contraceptive needs, applying a methodology outlined in the Strategic Approach to Strengthening Reproductive Health Policies and Programmes developed by the World Health Organization (WHO).[1] Supported by WHO and the Population Council, the assessment proved pivotal in shaping the future of reproductive health services in Zambia (*2*). It identified key health policy concerns, provided a framework for research on contraceptive introduction, and served as a catalyst for the development of Zambia's first family planning service delivery guidelines. It also influenced the procurement of new contraceptive methods and the phasing-out of others, such as high-dose oral contraceptives.

Based on the assessment's recommendations, a number of pilot studies were eventually carried out, each of which sought to strength-

[1] The WHO Strategic Approach is a systematic, three-stage approach for identifying and prioritizing reproductive health-care needs, for testing practical solutions to those needs and for bringing to scale the successes, taking account of the lessons learned (*1*).

en the availability of new and/or underutilized methods, while at the same time using the introduction of those methods as a means to improve the quality of services in general. The largest and by far most ambitious of these studies took place between 1996 and 2000 among selected health centres in three newly created rural health districts of the Copperbelt Province. The impetus behind the study was twofold: first there was the low utilization of contraception, and second was the dramatic imbalance in the composition of Zambia's limited method mix. In 1995, contraceptive prevalence of modern methods was only 7%, with half of all users opting for the pill, and the other half relying primarily on the intrauterine device (IUD) and sterilization (2). The explanation had to do with the weak public sector service delivery system, poor provider competence, limited access to services by large segments of the population, and – in contrast to its neighbouring countries – the virtual absence of any injectable contraceptive in the public sector.

For many years, depot-medroxyprogesterone acetate (DMPA) was a popular method among Zambia's family planning users. By the early 1980s, however, reports of its abuse in neighbouring Zimbabwe (previously Rhodesia) sparked calls for its removal from public sector services. Derided within the Zambian medical establishment, and blamed for side-effects for which there was no medical basis, DMPA was soon withdrawn from the national contraceptive method mix.

On field visits conducted during the 1995 strategic assessment, demand for the long-acting injectable was still widespread, particularly among rural women for whom the burdens of contraceptive resupply were particularly heavy. At the time, other contraceptive methods were frequently out of stock, and the existing logistics system did not supply facilities with sufficient stocks to allow advance distribution of oral contraceptives on any meaningful scale. The biases against DMPA, however, also remained strong. Many senior Ministry of Health staff had been providers when DMPA was withdrawn and still felt the impact of their exposure to the negative publicity. Field-based staff, by contrast, exhibited far fewer biases and many of them felt it was important to reintroduce the product.

The assessment concluded that fundamental changes were needed in the provision of reproductive health services and especially in the composition of Zambia's method mix. In part, this meant a reintroduction of DMPA. Even more critical was the need to broaden method choice overall. Although the range of methods theoretically available to public sector clients was broad, the weak service delivery system meant that few rural facilities ever had more than one or two methods in stock. On the rare occasion where more methods were available,

poor provider training meant that staff were often unfamiliar with them or, in the case of brands of oral contraceptives, their different formulations.

The assessment's recommendations found a receptive audience. Within one year, the Ministry of Health and CARE International, a nongovernmental organization, had agreed to conduct a pilot study that would enhance contraceptive choice in three newly created districts of the Copperbelt Province. Technical support for the development and implementation of the project was provided by WHO and the Population Council. In April 1996, the pilot study got under way. Employing a quasi-experimental research design with 11 experimental and 10 control health centres, the study tested the effectiveness of new service delivery and training strategies, as well as the introduction of new contraceptives.

The years of the pilot study were a tumultuous period for Zambia's public sector health-care system, as implementation of the national health reforms had begun in earnest. The reforms embodied many features now common to health reforms worldwide, including decentralization and greater autonomy for the regions, and increased efforts at cost recovery. However, a distinctive feature of the Zambian model was the transfer of all service delivery responsibilities from the Ministry of Health to a newly formed Central Board of Health, and the reclassification of all public sector providers from permanent civil-servant status to limited-term contractors.

By obliging health personnel to reapply for their own positions, the reform process created uncertainty throughout all levels of the health system. Policy-makers were unclear about the direction the reforms were taking and were unwilling to commit either human or financial resources to new programmes or projects. Equally affected were the providers, whose lack of job security undermined efforts to strengthen services, introduce new training programmes, or engage in potentially sensitive activities such as introducing injectables – or even showing support for such a move.

The process of reform severely affected the pilot study. Turnover, especially among trained staff, was extremely high. By the end of the project's second year, only about a third of its 20 or so trained providers were still active. The reform process also undermined the study's strategy to use evidence to change attitudes and policy. Although key reproductive health managers in Lusaka routinely received project data and visited participating districts, they were often hesitant to forward their observations to senior administrators with the power to change policy. Like their counterparts at the service delivery level, managers were understandably reluctant to stand out or challenge the

status quo. Ultimately, such fears led to a hiatus in project activities of over a year.

Four years after it began, the pilot study formally ended. Findings were presented at a two-day dissemination workshop in Ndola, capital of the Copperbelt Province, which was attended by more than 60 participants, including four members of the original strategic assessment team (*3*). Data from service statistics, an internal mid-term evaluation, feedback from the three participating health districts, and pre- and post-intervention situation analyses left little doubt that the study had had major impact on the scope and quantity of services at the 11 participating health centres. Under the leadership of a project manager, contracted by the Ministry of Health, the pilot project had trained health-care personnel in the provision of family planning services; it had provided more specialized training in IUD insertion and the screening and treatment of sexually transmitted infections (STIs), improved counselling tools and strengthened providers' counselling skills. It had also established referral systems; introduced three new contraceptives – DMPA, the female condom and emergency contraception; and furnished the centres with new supplies and equipment.

The project also employed a variety of media to communicate its accomplishments. For example, it introduced a local newsletter, which highlighted the contributions of all health facility staff – from providers, to messengers, to management. It also successfully mobilized villages to play an active role in the delivery and management of reproductive health services, seeking out the support of local opinion leaders and working through the mechanism of the local chief's tours.

At the service delivery level, the impact of study interventions was also evident. Data collected by CARE indicated substantial increases in contraceptive usage as well as a significant broadening of the overall method mix. In the 24 months following the start-up of field-based interventions, for example, the average number of new contraceptive users per quarter (480) was over twice that of the quarter prior to the study intervention (220). Finally, the study saw improvements in quality of care, as measured by baseline and end-of-project situation analyses (*4*).

After two days of discussion, the dissemination workshop recommended that the study's interventions be scaled up throughout all eight of the Copperbelt's rural and peri-urban health districts. Participants also provided direction as to how the effort should take place. They suggested, for example, that the equipment, supplies and even personnel involved in the pilot study should not be absorbed into routine operations of the Central Board of Health, but should rather be reserved for the scaling-up effort. They also recommended that the

new contraceptive methods introduced by the pilot study be distributed through the public sector logistics system. Finally, workshop participants called on the Ministry of Health to formally recognize the important role of DMPA within the method mix and support its full incorporation into the service delivery system. Within one month, the Central Board of Health approved these recommendations and gave a green light to scale up efforts to enhance contraceptive choice and improve quality of care throughout the Copperbelt.

A conceptual framework for scaling up

In the months following the dissemination workshop, the team responsible for drafting the intervention plan – the project manager of the Copperbelt study, the director of the Copperbelt Provincial Health Office, and a technical adviser from the Population Council – found themselves grappling with a host of operational issues. On one hand, they recognized that scaling up would imply a massive undertaking: the number of service delivery points, for example, would increase almost fivefold from 11 to at least 48, while the population of the districts covered would jump from 238 000 to roughly a million. At the same time, they acknowledged that key aspects of the scaling-up process remained unclear: Which activities would be scaled up? Who would do what? And how and when would the scaling up take place?

As the team grappled with possible answers to these concerns, they gradually came to realize that these three issues were not just isolated sets of problems, but were interrelated and in fact encompassed the central programmatic issues and challenges associated with scaling up in general. This realization led the team to adopt these concerns as the main axes of a simple, yet ultimately effective framework to guide the design of the scaling-up process. The framework, illustrated in Figure 4.1, is represented as a triangle, with each point corresponding to one of the three key concerns: the *content* of intervention activities (what is to be scaled up?); the *process*, that is the breadth of scaling up over time and place (where and when would it be done?); and the *organizational implications* of scaling up (who would do what and how, and by what mechanisms?). These constituent parts of the framework are discussed on the following pages.

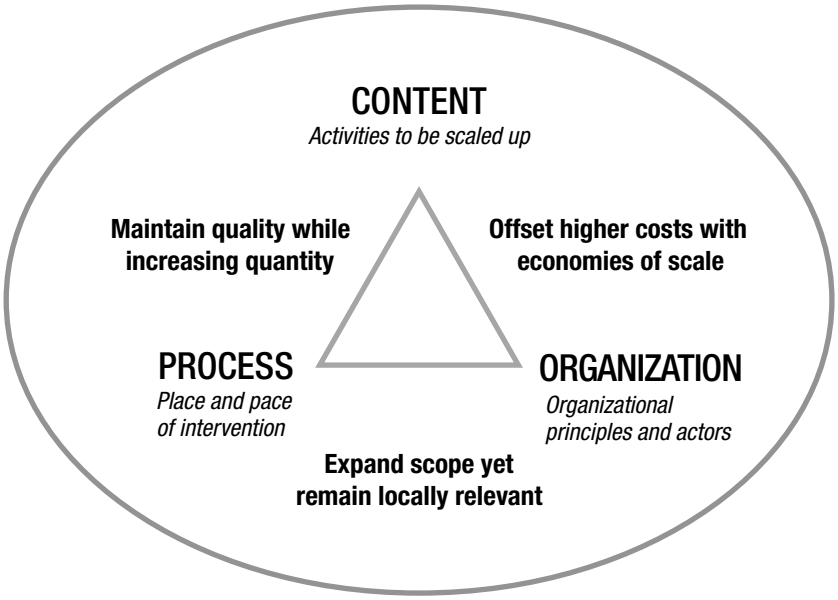

Figure 4.1 A conceptual framework for scaling up pilot interventions

Content

The literature on large-scale transitions to quality of care highlights the dangers of piecemeal approaches to scaling up, because they often sacrifice the integrity and cohesion of the intervention for the sake of operational expedience (Chapter 1). At the same time there is a need to simplify complex interventions to help facilitate their sustainable scaling up. In many pilot initiatives, the range of potentially replicable interventions can be immense. In the Copperbelt pilot study, for example, numerous activities were undertaken and tested; yet nowhere was there evidence to suggest that the study's success depended on the presence of each one. A dilemma facing any design team, therefore, is in deciding what – out of the vast experience of a pilot study – makes the most sense to introduce or expand. In the conceptual framework shown in Figure 4.1, this question is addressed by the dimension of content.

In the case of the Copperbelt pilot study, the design team reviewed the existing data, consulted extensively with district planners and providers, and concluded that the study's success rested not on any single intervention but on a combination of the study's three main focus areas: broadened method choice, improved technical competence of pro-

viders and strengthened linkages between community and the health sector. It was around these foci, therefore, that the design team chose to structure the content of the Pilots to Regional Programmes (PRP) initiative. In the case of broadening method choice, efforts involved the establishment of a minimal method mix – a set of contraceptive methods to which any client attending any participating health centre would be guaranteed access.[2] Broadening method choice also included a host of support activities needed to sustain the mix, such as functioning logistics mechanisms, referral systems and outreach mechanisms.

A second set of activities was intended to ensure provider competence. This included ongoing technical support, supervision and the implementation of both traditional and innovative self-directed training approaches.

The third set of activities entailed forging linkages between the community and the formal health sector, and within the health sector itself. These interventions involved the innovative use of local chiefs and other traditional leaders to disseminate information about reproductive health; the active involvement of project staff in community-based sensitization meetings; the revitalization of community-based health associations or "neighbourhoods", safe motherhood committees and "circles of friends"; and the publication of newsletters to share the experiences of health-care providers.

Process

The second dimension of the conceptual framework relates to the spatial and temporal aspects of the scaling-up effort. These include both the geographical scope of the intervention as well as the timing or pace of implementation.

The selection of health facilities to launch the scaling-up process was no easy task. The districts (and facilities within them) were markedly diverse with respect to their degree of urbanization, population size and density, level of health-care services and contraceptive prevalence. They were also diverse with respect to their exposure to the content of the interventions, as three of the eight districts contained health centres that had already participated in the initial pilot study. The playing field, therefore, did not start out even, and the political implications of some districts benefiting more than others figured prominently in the design process.

---

[2] Under the PRP initiative, the minimal method mix includes male and female condoms, a dedicated emergency contraceptive pill or combined oral contraceptives repackaged for emergency contraception use, the intrauterine device CuT380, DMPA, both a combined and a progesterone only contraceptive pill, bilateral tubal ligation and the Standard Days Method.

On the issue of timing, several possibilities presented themselves. Would scaling up start in the three original districts, expand to facilities never reached during the pilot, and then gradually move out to encompass facilities in the remaining five districts? Or would it begin by giving all eight districts an initial equal taste of what the project had to offer? Ultimately, considerations over content and timing converged. PRP would begin simultaneously in all eight districts, but the approach would be gradual, starting with a series of targeted interventions in at least two service delivery sites (designated as centres of excellence) per district and achieving district-wide coverage by the end of the initiative.

Implementation progressed through three distinct phases of varying lengths. During the first phase, which averaged about 18 months, 21 centres of excellence implemented a basic package of interventions. The package included the introduction of a common set of contraceptive methods and services, the application of innovative training strategies and the establishment of new community-based initiatives. The primary goal of this phase was to guarantee minimum standards of quality of care at each centre of excellence, so that they could serve as demonstration sites that could expose the other facilities to the full range of activities.

The second phase of the scaling-up effort entailed a process of reflection and analysis, culminating in the formulation of district-specific implementation plans. Over a period of about three months, each district set out its long-term goals with respect to the three content areas: contraceptive choice, provider competence and community linkages. This strategy ensured that each district only scaled up what made sense to them, and that each package of interventions reflected the unique characteristics of the district in which it was being implemented. This tailoring was seen as an indispensable element in balancing the inherent tension between the growth in the number of participating service delivery sites and the level of resources required to ensure the quality of the intervention.

During the third phase, which again lasted approximately 18 months, the bulk of the initiative's resources were used to help districts implement their plans, using the centres of excellence as springboards to expand interventions to neighbouring health-care facilities and communities.

Organization

The third dimension of the conceptual framework involved the organization of the scaling-up effort. How was scaling up to be done, by whom, and by what mechanisms?

Implementation of activities under the pilot study was carried out by two organizations, CARE International and the Zambia Central Board of Health. Both agencies followed a single protocol, but the responsibilities and funding sources of each were distinct. Their involvement was coordinated from Lusaka, where the headquarters of both were situated. As the design team turned its attention to organizing and managing a province-wide intervention, it soon became evident that the top-down, parallel structure of the pilot study would no longer be appropriate. Scaling up demanded more coordinated funding and management. It required strengthened communication and local transport, and it needed mechanisms to ensure that the interventions reflected the different needs and capabilities of the districts where scaling up would occur. Considering economies of scale also took on far greater importance. These factors pointed towards stronger horizontal linkages among districts, greater local ownership and a consolidation of management roles and responsibilities.

In responding to these needs, the design team proposed a new organizational structure that would be fully integrated with existing public sector services at both the provincial and district levels. Under this arrangement, management responsibility for the initiative fell to the Director of the Copperbelt Provincial Health Office and a team of technical advisers, led by the former project manager of the pilot study. Working hand in hand with coordinators designated by each participating health district, the advisers helped design and support activities in each of the three content areas: expanding contraceptive choice, training and the establishment of community outreach. From the start, programme implementation became a collaborative effort between the province, which provided technical and financial support, and the districts as the local coordinating and implementing agencies. Over time, however, the role of the Provincial Health Office diminished as districts gradually assumed responsibility for the content and pace of the scaling-up process. From the reflection and analysis phase onwards, it was the districts that determined which interventions would be expanded and how the expansion would take place. As districts recognized the advantages of reducing costs and maximizing economies of scale, they began to take control of management decisions, pool resources and share expenses. The Provincial Health Office did continue providing technical and financial support, but the organizational structure of PRP became less centralized.

Resolving tensions of the scaling-up process

Since its launch in 2002, the Pilots to Regional Programmes initiative has earned itself the reputation as being an innovative and cost-ef-

fective programme for scaling up high-quality family planning services in rural and peri-urban areas of Zambia. It has been the subject of rigorous observation and widespread dissemination, both nationally and regionally, and it has played a pivotal role in the introduction of new contraceptive technologies, including the formal registration in 2005 of the injectable contraceptive DMPA with the Zambia Drug and Poisons Board (*5*). Contraceptive prevalence in the Copperbelt's eight districts is now among the highest in rural Zambia, with many women having access to methods and services typically available only in urban settings. PRP's ability to respond to regional differences and local needs has prompted requests by the Central Board of Health and the donor community to scale up to national coverage. How, then, can this success be explained? How did use of the conceptual framework guiding the development of scaling-up strategies contribute to the success of the initiative?

Internal tensions are, to some degree, inherent in any scaling-up effort. The project design team found that the interrelationships between each point of the framework offered a practical entry point for relieving many of these tensions, thereby minimizing their impact at the outset. The inverse relationship between quality and quantity (or scale), for example, is one linkage the design team found could be addressed through interventions relating to content and process. Similarly, the dimensions of content and organization provided ample opportunities to maximize efficiencies and thereby minimize the higher costs of moving to scale. Finally, the relationship between process and organization highlighted the trade-offs between broadening geographical coverage and maintaining responsiveness to local needs and circumstances.

The conceptual framework rendered these conflicts more manageable and provided the team with a practical tool for making sense of the ambiguities associated with moving from pilots to regional programmes. How this was achieved is explained below.

Quality versus quantity: linking content and process

In moving to scale, the notions of quality and quantity are often at odds. As output increases – be it of services, clients or trained staff – the input required to sustain it should in relative terms decline, but it is precisely that decline in inputs (with its associated efficiencies and cost-savings) that can threaten the attributes that made the pilot intervention(s) so successful in the first place (*6*). PRP's response was to strike a balance between the two extremes – to maximize economies of scale while at the same time preserving the attributes of local control and management. It achieved this balance by exposing districts

to a common set of strategies for addressing the three focus areas, but then allowing them to adapt the content of those strategies and to pace themselves with respect to their implementation. Key interventions across the three focus areas were built on common foundations and principles, but the precise timing and content of those interventions depended on decisions taken at the district level.

One of the best examples of this interface between content and process was the phased application of PRP's two training programmes for providers: a traditional classroom approach for training of trainers, and an on-site self-directed learning programme that enabled providers to follow a more flexible, independent course of readings and exercises, closely supervised by routine visits from district and/or project staff. Technically, both programmes offered equally effective and equally comprehensive instruction in the delivery of reproductive health services. Programmatically, though, their greatest strength lay in their adaptability to the constraints and realities of ever-evolving social and environmental contexts. Under the self-directed programme, for example, the cost per trainee was less than half that of the classroom alternative, but the self-directed programme was far more time consuming and was also dependent on adequate access to transport by district supervisors, something that not all districts could provide equally well. The classroom approach, in contrast, offered speed and efficiency, but it also meant removing providers from their local health facilities, which rural districts (and even many urban ones) with health posts staffed by one or two persons cannot easily afford to do.

The phased intervention process worked by exposing all the districts to the two broad training regimens, and then by providing them with the authority to decide what made most sense locally and the flexibility to pace themselves – to apply the right strategy at the right time. As services at health facilities were scaled up, the demand for trained staff increased. At no time, however, did that demand force districts to compromise quality of the training effort by implementing cost-saving measures such as: pushing the limits of classroom size, reducing the face-to-face interaction between instructors and trainees, following a single PRP-wide training schedule, or implementing approaches they could not afford. Instead, the ability of districts to pace themselves and to choose the format of their training activities meant that they were able to respond appropriately to local variations in staff attrition, service expansion and resource availability. At any given point in time, someone in some district was being trained, either on site or centrally. Within the first two years of the project, the districts had successfully trained 120 formal sector service providers – six times the number trained during the entire life of the initial pilot

study – 41 of whom were trained under the self-directed programme and 79 in formal classroom settings. More specialized trainings were also conducted, particularly to increase access to IUDs. In addition, the districts hired and trained 205 community-based distributors and over 500 community-based counsellors of the Standard Days Method. By retaining control of the process and determining when training was appropriate, the districts trained more people than ever before, but on a scale that was manageable and appropriate to their needs, without ever compromising the quality or integrity of the training itself.

Maximizing economies of scale: linking content and organization

Scaling up always implies a tenuous balance between the increase in inputs needed to expand activities and the level of benefits expected. In the previous section, managing this trade-off entailed both the application of different interventions and the delegation of authority to apply those interventions in ways that best suited the needs of each district. The focus in that instance was very much on local autonomy and the realities of that locality. The imbalance between inputs and outputs can also be corrected effectively through greater integration, specifically by exploiting the potential synergies that exist across districts. By maximizing economies of scale and realizing the efficiencies that come from such scale, districts can vary the content of their programmes without undermining either their integrity or quality.

One notable example of such synergies was in the area of contraceptive choice. As noted earlier, the cornerstone of expanded choice under PRP was the right of every health facility client to have access to a minimal mix of contraceptive methods, either directly at the service delivery point or through an efficient referral system. Although all districts agreed to offer such a minimal mix, they recognized that no single approach would apply to all. Dedicated or even repackaged emergency contraception pills were not initially available in Zambia, female condoms were in short supply, and the provision of long-term methods such as injectables and IUDs had always been especially problematic at smaller facilities. For many districts, therefore, filling these gaps would have implied overwhelming investments in time and resources.

The strategy to synchronize content and achieve economies of scale operated at two levels. At one level, it allowed districts to achieve the critical mass necessary to justify large-scale production or even procurement of needed goods and services. One example of this was emergency contraception. The absence of a dedicated product undermined PRP's ability to ensure quality contraception services. Therefore, the decision was taken early on to repackage combined oral contraceptives

for emergency contraception. Though widely practised throughout the world, the repackaging effort in Zambia was, from the start, a highly complex, labour-intensive endeavour. It involved the large-scale procurement of commodities from central Ministry of Health stores, along with the authorization to repackage them from the national Drug and Poisons Boards. It required letters of support from international agencies and entailed the production of appropriate packaging consistent with national requirements. Finally, it involved the repackaging of the commodities themselves. The effort required to produce a repackaged emergency contraception pill was substantial and would not have been justified by the demand generated by just one or two individual districts. It was made possible by strong central management at the provincial level, and by the fact that the production levels needed to make the effort worthwhile were commensurate with the demand for the product by all eight districts.

Maximizing economies of scale also proved highly effective in dealing with resource disparities horizontally across the Copperbelt's eight districts – disparities that in many cases affected the districts' ability to provide certain contraceptive options. One approach involved a cost-saving scheme that rewarded districts for contributing to the broader implementation of PRP interventions. The contributions could be in kind, such as food and refreshments during provider trainings, or fuel and vehicle use for supervision, or they could include the services of skilled personnel for training, supervision or service delivery. In return, districts received a credit, which they could then redeem for resources from recipient districts, or for supplemental financial support to undertake activities related to broadening method choice, strengthening technical competence, or enhancing community outreach.

Though simple in theory, implementation of the credit scheme proved challenging, especially the formulation of formal exchange mechanisms. However, it moved forward, in large part because of strong interdistrict collaboration and ongoing support from the project manager. The scheme did, for example, prompt certain districts, particularly those in peri-urban areas, to provide IUD insertions on a mobile basis and train providers from neighbouring districts. In other instances, referral fees were eliminated at urban hospitals in exchange for greater efforts to meet client needs at rural tertiary facilities. In some cases, hospital staff even began outreach activities, offering more advanced technical skills to meet the needs of their rural neighbours.

The strengthening of interdistrict linkages also made it possible to maximize economies of scale by encouraging districts to pool assets and exchange material resources such as transport, training facilities,

equipment and supplies. By the second year of the initiative, the districts were conducting joint training; they were collectively procuring equipment, supplies and commodities and collaborating on other activities, such as annual planning, that they once pursued on their own. They also introduced a series of exchange programmes, whereby staff from one district served as external observers and examiners in the training programmes of another. In short, the organizational structure facilitated the expansion effort and, in the process, increased efficiency by reducing duplication. Now all districts are providing more clients with more methods than ever before. The number of new contraceptive users at participating health centres, for example, has risen steadily from approximately 1000 per quarter to current levels of almost 3000. The expansion has taken place within the context of diverse service delivery schemes, tailored to meet the unique conditions of each district, with some relying more heavily on referrals and others providing a wider range of methods on site.

Remaining locally relevant in the midst of expansion: linking organization and process

The move to scale is often characterized by the tendency to formalize and standardize roles, responsibilities and procedures (see Chapter 2). In some ways, the trend is paradoxical, for as systems are being formalized, the environments within which they operate typically become more diverse and complex. Whether it is more people, more districts or more municipalities, there is always the risk that the interventions become less appropriate for the diverse contexts in which they will be applied. A major challenge of the scaling-up process, therefore, was to ensure that expansion did not occur at the expense of relevance or local ownership.

Under the initial pilot study, a host of interventions were introduced to encourage communities to adopt a more active role in the management of health sector interventions and to increase awareness of reproductive health risks. Many of these, such as chief's tours, community discussions and outreach services, have already been mentioned. Though the designers of PRP drew heavily on the experience of these interventions, they also recognized that these activities alone could not guarantee ownership of PRP or even buy-in on the part of those communities affected by it. To make the content of PRP as meaningful and relevant as possible, therefore, the pace of the intervention process was tied to the evolving management responsibilities of the participating districts – in other words, to the dimension of organization. As the districts assumed greater control over the direction and management of activities – particularly after the formal handover of

decision-making authority in phase two of the scaling-up process – they were empowered and encouraged to tailor interventions to reflect local needs, implementation capacities and interests.

The devolution of management responsibilities was facilitated both by the phased implementation process and by a number of activities focused on the third content area, community linkages. One such activity was the decentralization of information. Building on the experience of the earlier pilot study, PRP reintroduced in 2002 an illustrated newsletter that brought to life many of the initiative's major accomplishments and findings. Geared to front-line health-care workers, the newsletter nevertheless circulated widely among planners and decision-makers at all levels of the health-care system. The dissemination of information also relied on face-to-face contact. At various points during the life of the study, meetings were held to disseminate research findings, particularly the results of surveys and evaluation activities.

A second strategy to encourage local control over the implementation process was to ensure the involvement of key community members, including traditional authorities and other cultural leaders. In some communities, local chiefs were mobilized to support PRP initiatives and advocate for behaviour change. In others, technical staff helped traditional counsellors to incorporate reproductive health messages in their counselling of young women at key rites of passage associated with menarche and marriage. Finally, PRP capitalized on the dominant role of men in both community and domestic life by involving them as health agents and spokesmen for programme initiatives. This was especially successful in the promotion of the Standard Days Method.

As a result of these interventions, communities are today exercising a more direct role in shaping the kinds of health services available to them. Chiefs and other local leaders, for example, have actively lobbied districts to extend the operating hours of local clinics – they have even called for the replacement of poorly performing health personnel. Local development committees are also exerting more direct influence over the day-to-day operations of their health facilities. Some, in fact, were instrumental in ensuring that certain contraceptive options, such as natural family planning, were made available locally. Even at the individual level, community members now report that PRP's emphasis on choice has demonstrated to them the importance of this factor, and has given them the confidence to demand choice in all aspects of health care.

Conclusion

The greatest challenges in scaling up reside in the practical, organizational transformation of a small pilot study to a broad-based

programmatic intervention. It was the resolution of strategic choices concerning content, process and organization that forced those planning the PRP initiative to come to grips with such issues as scale, context, organization and sustainability. And it was the design of effective strategies that yielded the results and successes described in the previous pages.

Now all eight of the Copperbelt's rural and peri-urban districts have in place organizational mechanisms for supporting PRP interventions that are fully integrated into their existing operational structures and sustained financially by the province and districts themselves. The Zambia Ministry of Health has formally identified the PRP initiative as a best practice in reproductive health and has selected its framework as the model for scaling up reproductive health services over the coming decade. The Ministry has also requested assistance from the Population Council and WHO to develop funding proposals that will make such an expansion possible.

However, the sustainability of PRP will not depend on the province alone or on the enthusiasm of the Ministry of Health. The national health system itself is once again undergoing major reforms – reforms that even include the abolition of the Central Board of Health. The Copperbelt, too, is undergoing social and economic change as reopened mines breathe life into once economically depressed areas and once active areas slide into decline. The end of funding to PRP from the United States Agency for International Development (USAID), which occurred in August 2005, is testing the initiative's sustainability, the depth of its local ownership and the degree of public sector confidence in its ability to scale up reproductive health services. Whether the participating districts and provinces can sustain their commitment to the activities of PRP remains to be seen. There can be little doubt, however, that the conceptual and practical lessons derived from the scaling-up process will play a critical role in future efforts to expand and improve the quality of reproductive health services in Zambia.

Acknowledgements

The activities described in this chapter span nearly a decade and involve a cast of characters far too numerous to name, and far too important to describe in a sentence or two. Singling out individuals for special thanks is always fraught with peril, but it would be equally perilous to ignore the contributions of those who were truly indispensable in the successful transition from pilot to regional programme. These include the late Dr John Mbomena, team leader of the 1995 Zambia Contraceptive Needs Assessment and the inspiration for many of the activities described in this report; Dr Eddie Limbambala and Dr Simon

Miti, whose courage and, most importantly, willingness to exercise authority helped the pilot study overcome so many of the obstacles put before it; and Ms Tamara Fetters and Dr Miriam Chipimo, each of whom provided the technical guidance and programme oversight required to sustain the transition from the initial assessment to regional programme.

From assessment, to pilot study, to scaling up, USAID/Zambia and WHO were steadfast, sustaining the process, both financially and technically. They were joined in this effort by other key partners, such as the Population Council, CARE International, Georgetown University's Institute for Public Health, the Canadian Public Health Association, and of course the Zambia Ministry of Health, the Central Board of Health, the Copperbelt Provincial Health Office and the eight participating District Health Management Boards.

References

1. Fajans P, Simmons R, Ghiron L. Helping public sector health systems innovate: the strategic approach to strengthening reproductive health policies and programs. *American Journal of Public Health*, 2006, 96:435–440.

2. World Health Organization and Zambia Ministry of Health. *An assessment of the need for contraceptive introduction in Zambia. Research on the introduction and transfer of technologies for fertility regulation*. Geneva, UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, 1995.

3. *Enhancing contraceptive choice and improving quality of family planning services in Zambia. Proceedings of dissemination workshop, Ndola, 25 January 2001*. Lusaka, Zambia Central Board of Health/Population Council/CARE International, 2001.

4. Muvandi I, Butrick E, Skibiak JP. *Measuring quality of care: a comparative analysis of situation analyses carried out in 1997 and 2000 under the Enhancing Contraceptive Choice and Improving Quality of Care Project*. Nairobi, The Population Council, 2001 (unpublished report).

5. Solo J, Luhanga M, Wohlfahrt D. Ready for change: a repositioning family planning case-study. New York, The ACQUIRE Project/EngenderHealth, 2005.

6. Korten DC, Klauss R, eds. *People-centered development: contributions toward theory and planning frameworks*. West Hartford, CT, Kumarian Press, 1984.