

ENHANCING
CONTRACEPTIVE
CHOICE AND
IMPROVING
QUALITY OF
FAMILY PLANNING
SERVICES IN
ZAMBIA

DISSEMINATION WORKSHOP
REPORT OF PROCEEDINGS

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ZAMBIA CENTRAL BOARD OF HEALTH
POPULATION COUNCIL
CARE INTERNATIONAL

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INTRODUCTION

In 1996, the Zambia Central Board of Health (CBoH) and CARE International launched a pilot study to develop and test a package of integrated family planning services for expanding contraceptive choice. Entitled *Enhancing Contraceptive Choice and Improving the Quality of Family Planning Services in Zambia*, the study trained health care providers across the rural Copperbelt to deliver high quality family planning and reproductive health services. It introduced three new contraceptive methods and it established referral systems for those not available locally. Finally, the study provided routine technical back-up to field-based staff; it supported ongoing logistics systems to avoid contraceptive stock-outs; and it took an active role in forging stronger linkages between health centers and neighboring communities.

In September 2000, the ECC study officially ended with the expiration of the two technical agreements through which the study's principal supporting agencies, USAID and WHO, had funded intervention activities. On January 25, 2001, a one-day workshop was held at Ndola's Mukuba Hotel to present the findings of the study and to assess local interest in scaling-up on a Provincial-wide basis, the lessons learned from it.

The Workshop was attended by more than 60 participants, drawn from CBOH, WHO, USAID, Population Council, Unicef, Ministry of Health, CARE Zambia, and Reproductive Health Alliance Europe. Also in attendance were the Directors of nine Copperbelt Health Districts, their MCH Coordinators or Managers of Planning, Health Providers and Community Representatives. A list of participants is contained in Appendix 1.

WELCOME AND OPENING REMARKS

To open the workshop, Acting Provincial Health Director, Dr. Peter Mijere, welcomed the assembled participants to Ndola. He thanked the organizers of the event, saying it was an honor for the Provincial Health Office to have played so key a role in the workshop's implementation. Dr. Mijere singled out for special thanks the many health care providers and community members who had come from all corners of the Province to share their views of the ECC Project and its impact on their lives.

While awaiting the arrival of the Guest of Honor, Dr. Mijere outlined the objectives of the workshop and reviewed the day's agenda, highlighting the main themes and issues to be covered during each discussion session. The introductions concluded with Dr. Mijere inviting each the assembled guests to introduce themselves

KEYNOTE ADDRESS

The Guest of Honor, Director General of the Central Board of Health, Dr. G. Silwamba, was officially represented by Dr. S. Miti, former Director of the Copperbelt Provincial Health Office and current Director of Technical Services at the CBoH,

In his keynote address, Dr. Miti traced the origins of the ECC study to the 1995 Zambia Contraceptive Needs Assessment – a joint Ministry of Health/WHO effort intended to assess the adequacy, user responsiveness, and technical soundness of Zambia's contraceptive method mix.

Dr. Miti remarked that despite a long history of contraceptive introduction in Zambia, the country's method mix in 1995 was still very imbalanced. Almost half of all contracepting women were taking the pill, while use of the IUCD, diaphragm, foam, implants, and injectables was virtually negligible. Recognizing this imbalance, the Assessment called for fundamental changes in the provision of reproductive health services. It called for rationalization of the method mix; improvements in logistics and distribution; and for enhancing access to under-utilized contraceptives, particularly injectable contraceptives which, in every other country of the region, constituted a significant proportion of the overall method mix.

As Dr. Miti pointed out, the ECC Study came to life as a practical attempt to gauge the feasibility of implementing these recommendations. Targeting three newly created districts within the Copperbelt, the study sought to increase the choice of contraceptives available at service delivery points; overcome longstanding biases against technologies for which there was a demonstrable unmet need; and use existing knowledge in the development of strategies for expanding contraceptive choice.

Now that the study has concluded, Dr. Miti said the time had come to look with a critical eye at what was accomplished. Did the results of this study meet initial expectations? And are the results likely to influence or change the way we do business in the future? Aware that many in the room had come with firm intentions to scale-up the lessons learned, Miti reassured everyone that he would not pre-empt the day's proceedings by answering these questions on his own.

He did however; highlight a number of lessons that he hoped everyone would keep in the back of their minds as the day progressed. The first lesson was the importance of allowing women and men to decide for themselves which methods to use. The project had, he noted, substantially increased the range of methods available in rural Ndola. It had also introduced methods about which the Ministry and Central Board of Health would soon make some key policy decisions. But whatever one's personal beliefs might be about these methods, he said, if the choices women and men make are safe and informed, then it is their voice and their choice that we must respect.

The second lesson was the importance of local ownership in the research process. Dr. Miti acknowledged that the study had benefited greatly from a large cast of national and international participants. And while each had contributed to the success of this project, the project's long-term survival ultimately depended on the commitment and support of those on the ground in Ndola, Lufwanyama, Masaiti and Mpongwe.

The third lesson to be learned from the study was the importance in recognizing the unique constraints that face the delivery of health care services in rural areas and the need to adapt interventions to them. All too often, Dr. Miti said, we in the nation's cities design programs that reflect our own realities, "not those of our brothers and sisters who live in rural areas. We sponsor training sessions and just assume that providers will come without having to shut down operations. We justify interventions on scientific grounds, often without considering the social or cultural context within which such interventions take place. We generate information without concern as to how that information will reach those we expect to benefit from it. And we recommend treatment, including contraceptive methods, often with little consideration for the difficulties women face in seeking follow-up or re-supply."

Dr. Miti concluded his opening remarks by thanking the many participants who had come in hopes of carrying on the good work of this study in their own districts; and those participants whose financial resources would make this possible.

WHAT IS THE ECC STUDY AND WHY WAS IT UNDERTAKEN?

Peter Hall, WHO/Reproductive Health Alliance Europe
Monde Luhanga, Reproductive Health Specialist, CBoH
Christine Muntungwa, UNICEF
Rose Mulumo, YWCA
Evans Ndalama, Central Statistical Office

Given its roots in the 1995 Zambia Contraceptive Needs Assessment, five members of the original Assessment Team were invited to discuss their experience and observations of the exercise, review the origins of the ECC Study; and describe the rationale for its implementation.

The first presentation, given by Mr. Peter Hall of Reproductive Health Alliance Europe (RHAЕ), summarized the conceptual framework underlying the Assessment process. Known formally as the WHO Strategic Approach to the Introduction of Fertility Regulation Technologies – the framework was developed in response to earlier failures at introducing new contraceptive technologies in a sustainable manner with appropriate quality of care.



The WHO Strategic Approach differed from these earlier efforts in two important respects. First, rather than just assuming the introduction of a new technology to be desirable, the approach saw it as an issue to be determined locally. Through the implementation of broad multidisciplinary assessments, the Strategy assesses the appropriateness of introducing, re-introducing, or even removing a technology -- on the basis of technological considerations (such as its technical efficacy); sociological grounds (such as user needs, preferences and attitudes); and programmatic issues (the ability of the system to provide health services with appropriate quality of care).

The second distinctive feature of the *WHO Strategy* is that it comprises a three-staged program. In the event a decision is taken to move forward with changes in the method mix, the Assessment is followed by the implementation of research on service delivery issues such as management, provider-user interaction, and factors influencing method supply. Finally, at a third stage, research findings are scaled-up and applied to decision making, policy formulation and strategic planning.

As Mr. Hall pointed out, the Zambia Contraceptive Needs Assessment was one of the first assessments to be carried out under WHO's Special Program on Research

and Development on Human Reproduction. Sponsored jointly by the Ministry of Health (Division of Family Health), WHO and the Population Council, the Assessment Team comprised representatives of the Ministries of Health (MCH/FP, Statistics and Health Reforms Divisions) and Defense, Makeni Ecumenical Centre, Medical Stores Limited (MSL), Planned Parenthood Association of Zambia (PPAZ), Institute for African Studies (IAS), University Teaching Hospital (UTH), the YWCA, and the Zambia Information Service (ZIS).

Despite its focus on contraception and method choice, the Needs Assessment was broad in scope, touching on a wide range of substantive issues relating to reproductive health. It discussed, for example, such topics as gender and adolescent sexuality, the informal health sector, family planning policy, logistics and commodity distribution, and of course the availability and distribution of contraceptive methods.

In their discussions, panel members touched on each of these issues, emphasizing the participatory nature of the exercise, its national scope, and their ability to address issues not typically covered during more traditional health assessments. At the end of the day, the Assessment concluded that fundamental changes were needed in the provision of reproductive health services. It called for rationalization of the method mix; improvements in logistics and distribution; and for enhancing access to under-utilized contraceptives, particularly injectable contraceptives.

The ECC Study, therefore, was developed as a Stage II study to address precisely these concerns:

- to test the feasibility of enhancing contraceptive choice through an expansion of the overall method mix;
- to overcome biases against technologies for which there was a demonstrable unmet need; and
- to use existing knowledge in the development of strategies for expanding contraceptive choice, especially in rural areas which account for almost 60 percent of Zambia's population.

WHAT DID THE ECC STUDY DO AND WHAT WAS ACHIEVED?

Njekwa Lumbwe, CARE/Zambia
Elizabeth Butrick, Population Council
Mary Zama, Zambia Central Board of Health

As described by Ms. Njeka Lumbwe, Project Officer with CARE/Zambia, the ECC study involved two distinct phases: an exploratory phase to analyze and build on existing knowledge; and an experimental phase for testing the subsequent application of that knowledge.

The goal of the first phase, which lasted from October 1996 to March 1997, was to assemble a package of training, IEC and other related materials for expanding contraceptive choice at the community level. To do this, the project reviewed and documented the experience of the Ministry of Health and CARE at strengthening service delivery and introducing contraceptive methods at 26 health facilities in periurban Lusaka and Livingstone.

In close coordination with the appropriate health districts, case records were reviewed to determine overall changes in contraceptive method mix and patterns of method switching. In addition, interviews and focus groups were conducted with family planning users and providers to determine acceptance of available contraceptive methods as well as overall satisfaction with existing counseling and service delivery facilities.

Phase One concluded with a formal review by health professionals of CARE's training, research, and other technical support materials originally developed for use at urban-based health centers. The lessons of this review were then applied to develop an intervention strategy for field-testing during the second phase of the project. The strategy consisted of:

- *A training curriculum* for health care personnel. Based on the CARE Family Planning Facilitators' Guide, the curriculum encompassed all methods included within the National Family Planning Guidelines, including Depo-Provera®.
- *Improved management systems* for forging stronger links between District Health Management Teams (DHMTs) and health centers; and for ensuring adequate supplies of equipment and materials.
- *Outreach strategies* to give communities a sense of ownership over their health centers, while at the same time providing health care workers with the means to garner community support for the introduction of new services and methods.

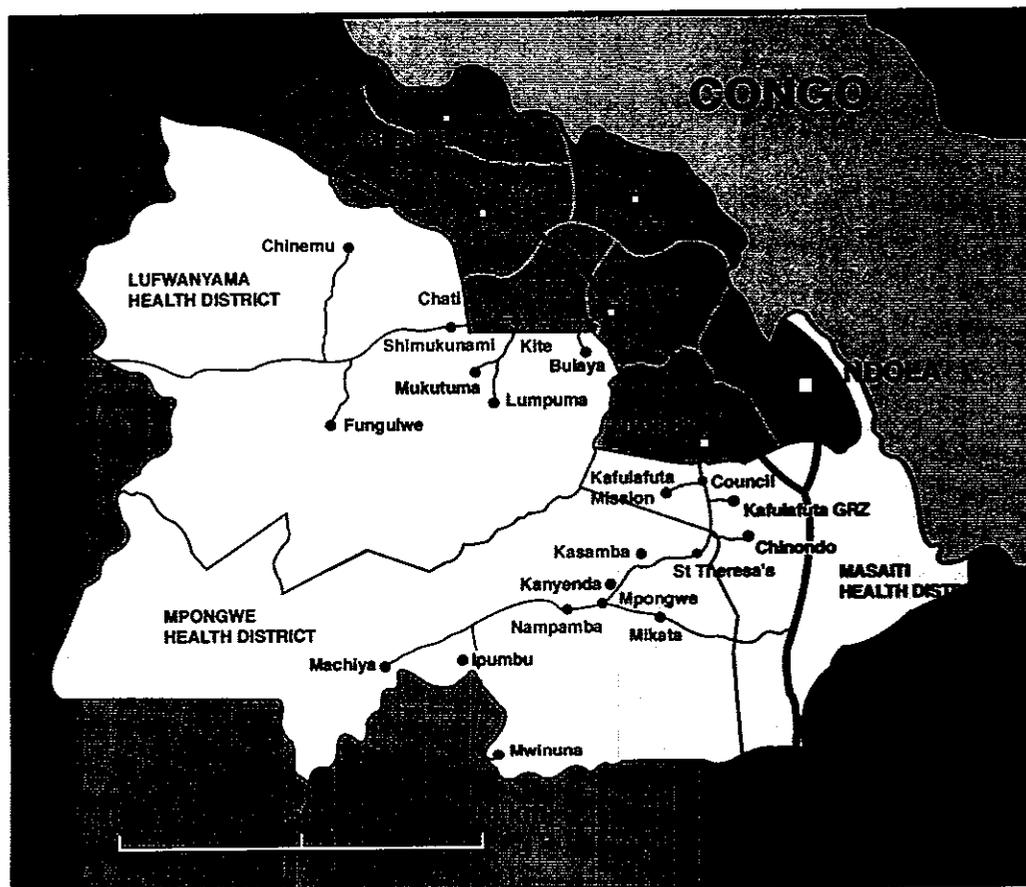
In April 1997, Phase Two of the study began with the training of health care providers; the strengthening of services; and the introduction of new contraceptive methods into three newly-created rural districts of Copperbelt Province (Mpongwe, Masaiti and Lufwanyama).

Building on the results of a baseline situation analysis, the goal of this phase was to test the effectiveness of the training, contraceptive introduction and service delivery strategies developed during Phase One; and to determine the feasibility of replicating them on a nationwide basis. It also, however, sought to assess the

demand and acceptability of a broad range of family planning methods, particularly those methods for which demand was high, but accessibility low.

Using a quasi-experimental research design of 11 case and 10 control sites, the study employed quantitative and qualitative methodologies to examine women's motives for method choice, continuation, and discontinuation. The study also analyzed providers' perspectives on available family planning methods and the service delivery system in general. Finally, the study investigated the technical and managerial adaptations necessary to provide improved quality of care in the public sector delivery of family planning services.

Figure 1
Map of Copperbelt Province,
indicating control (in black) and intervention (in red) sites
under ECC Project



WHAT HAS THE ECC STUDY ACHIEVED?

According to Ms. Elizabeth Butrick, Consultant for the Population Council, Phase Two of the ECC Study saw the scope and quality of services expand dramatically at the 11 participating health centers. Using the modified CARE curriculum, the project trained over 22 health care personnel in the provision of family planning services; it provided more specialized training in IUD insertion and in STD detection and treatment; and it improved counseling skills and tools. It established referral systems for methods not available at every health center. It made available methods that had previously existed only in theory, and it

introduced two new contraceptives into the method mix: the injectable Depo-Provera® and the emergency contraception pill, PC-4®. It furnished the centers with new supplies and equipment, including examining tables, sterilization equipment and basic consumables. And, finally, the project successfully mobilized communities to play an active role in the delivery and management of reproductive health services. Traditional birth attendants and community health workers received in-service training at all participating health centers; while health care personnel for the first time become involved in the annual *Chief's Tours*, ceremonial events during which local Chiefs visit all the villages and communities under their jurisdiction.

In addition to service delivery interventions, Ms. Butrick highlighted other outputs of the ECC Study. One of these was a bi-monthly newsletter designed to offer ideas on how to confront the challenges associated with implementation of the WHO Strategic Approach. Entitled *Solutions*, the newsletter featured such topics as community outreach, contraceptive supply logistics, and sustainability. During the life of the project, over 2000 newsletters were distributed to DHMTs, health care providers, and policymakers within the Central Board of Health.

A second major achievement of the ECC Project was the development of a draft "on-site self-directed training manual". Originally developed in response to the 1998 moratorium on the off-site training of health care workers, the manual makes it possible to train providers at small-scale, typically one-person health facilities without any interruption in services. As its name implies, the manual is a distance-learning tool which providers can use at their own pace to study the key components of family planning service provision. The lessons are supplemented by readings and by supervisory visits by project and/or DHMT staff. The manual is designed to take about 10 weeks to complete.

For participants interested in greater information about the manual, a display table was set up with sample lessons and an array of supplementary readings, including copies of the manual itself.

WHAT HAS BEEN THE IMPACT OF THE ECC STUDY AND WHAT WAS LEARNED?



Bernard Maswana, Masaiti DHMT,
Grace Phiri, Lufwanyama DHMT,
Rose Munkombwe, Mpongwe
DHMT,
John Skibiak, Population Council.

According to John Skibiak of the Population Council, the impact of ECC interventions on the quantity and quality of reproductive health services was assessed in two ways; the former through the collection and analysis of service delivery statistics; the latter through routine monitoring and the implementation of pre- and post-intervention situation analyses.

Throughout the target area as a whole, service statistics revealed substantial increases in the level of contraceptive usage; greater breadth in the method mix; and the widespread acceptance of new contraceptive methods, particularly injectables. During the first two years, for example, the average number of new acceptors per quarter was more than twice that of the quarter prior to the study intervention. The trend was illustrated with a slide showing that after an initial peak of 650 new acceptors between May and July 1997, the numbers of new acceptors eventually leveled off at between 400 to 500 per quarter. By contrast, the number of acceptors at the 11 control sites remained fairly constant throughout the duration of the ECC Study.

Method mix in the target area also changed dramatically. Prior to the start-up of the ECC project, pills and condoms made up almost 90 percent of all methods distributed to new acceptors in the target area. A year later, that percentage dropped significantly - in part because the percentage of injectable users had more than tripled from 9 to over 30 percent. But the increase in injectables did not just take place at the expense of former condom or pill users. As noted previously, the number of new acceptors per month had almost doubled by the end of the first year.

Equally as important as increased contraceptive choice were the consequences of that choice on method selection. Initially, concerns were raised that the introduction of DMPA might have a negative effect on the utilization of other contraceptives. Clearly, however, that did not happen. Despite their convenience and general popularity, injectables have not "swamped" other method choices. Condom use has remained fairly constant at 30 percent of the mix. If there has been any dramatic change, it has been in the relative decline in the proportion of women using oral contraceptives - particularly since the pre-intervention period, when they made up over two-thirds of the overall method mix.

Another important finding to emerge from the study, was the degree of user-preference for Depo-Provera® over the alternative two-month injectable, Noristerat®. Initially, injectables made up only a small percentage of the method mix; yet it was a percentage comprised exclusively of the brand Noristerat®, which was already available at some facilities in the study area. After twelve months, the percentage of injectable users had more than quadrupled; but almost all of them (90 percent) had chosen to adopt Depo-Provera®. According to client interviews, its greatest appeal was the fact it needed to be taken only once every three months (as opposed to every two months with Noristerat®) – a finding that supported the claim by the 1995 *Zambia Contraceptive Needs Assessment* that “in rural areas, distance, fears over erratic contraceptive supplies and limited accessibility to health facilities favor methods that minimize the inconvenience of continuous resupply or even daily administration.”

Also attesting to the importance of greater convenience, were the impressive continuation rates for injectables, Depo-Provera® in particular. At the smaller health centers, where outreach programs, community involvement, and client/provider counseling are especially strong and personalized, one-year continuation rates remained as high as 90 percent. In fact, the only significant declines in continuation (from 85 to 60 percent between the 4th and 5th injections) were evidenced at one particular health care facility, unduly affected by staff turnover and other disruptions attributable to the National Health Reforms.

To address the impact of ECC interventions on quality of care, Skibiak presented the findings of a new report comparing the study's pre- (1997) and post-intervention (2000) situation analyses. The report clustered the questions in the situation analysis instruments into the six categories or “elements” of quality of care. These elements included interpersonal relations; choice of method; information exchange; technical competence; mechanism to encourage continuity; and appropriateness and acceptability of services.

The results of the report suggested that between 1997 and 2000, improvements in quality were generally greater at the eleven intervention sites than at the control sites. Those indicators showing the greatest comparative improvement fell primarily into the categories of interpersonal relations, choice of method, technical competence and information exchange.

Using a series of slides, Skibiak selected several quality indicators to compare responses over time at control and experimental sites. One such example was awareness of a contraceptive method's ability to protect against STIs including HIV/AIDS. In 1997, both control and experimental sites performed poorly, with hardly any clients able to tell whether the method they had chosen offered protection or not. By 2000, however, over 40 percent of intervention clients could do so, compared to only 7 percent of control clients.

The panel discussion concluded with each of the participating DHMT Directors agreeing that health care services had improved dramatically during the intervention period. Communication between the neighborhood health committees and DHMTs had expanded as a result of more frequent meetings and the broader dissemination of information. Many providers also express greater pride in the quality of their services, which not only include a wider range of family planning methods, but greater competence in performing physical examinations and an increased number of male clients.

MASAITI DISTRICT

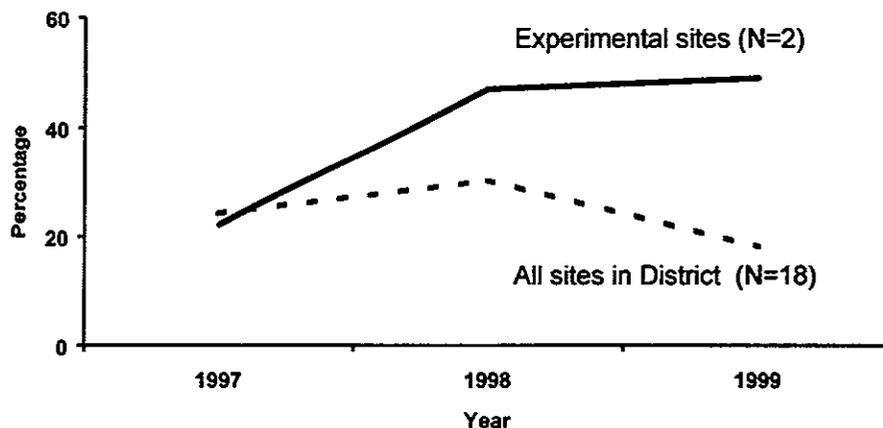


As the former Director of Ndola Rural District and a driving force behind the ECC Project's presence in the Copperbelt, Mr. Bernard Maswana initiated the panel discussion on project impact. He began by describing his current District, Masaiti, situated to the south and east of Ndola town. The District includes 18 rural health centers, most of which are located east of the Great North Road. The District's nearest referral hospital is located at St. Theresa Mission in Mpongwe District.

Following the 1997 division of Ndola Rural into three new Districts, Masaiti found itself with only two of the project's ten experimental sites: Kafulafuta Mission and Council Clinic. Both are located north of the Masaiti District office at a distance of 16 and 8 kilometers, respectively. Each enjoys electricity as well as year-round access to the tarred road that runs from Luanshya to Mpongwe. Because of the centers' location between the Kafulafuta and Kafubu Rivers, however, seasonal flooding regularly cuts off access to some of their surrounding communities.

In discussing the impact of the ECC Study, Mr. Maswana used service delivery statistics to illustrate dramatic improvements in contraceptive use at the two experimental sites. Since 1997, increases in new acceptors at these sites had surpassed levels for the district as a whole. This is shown in Figure 2, where Maswana compared the two in terms of achieved acceptor targets, the standard by which Districts traditionally measure their performance.¹

Figure 2
New family planning acceptors as a percentage of acceptor targets



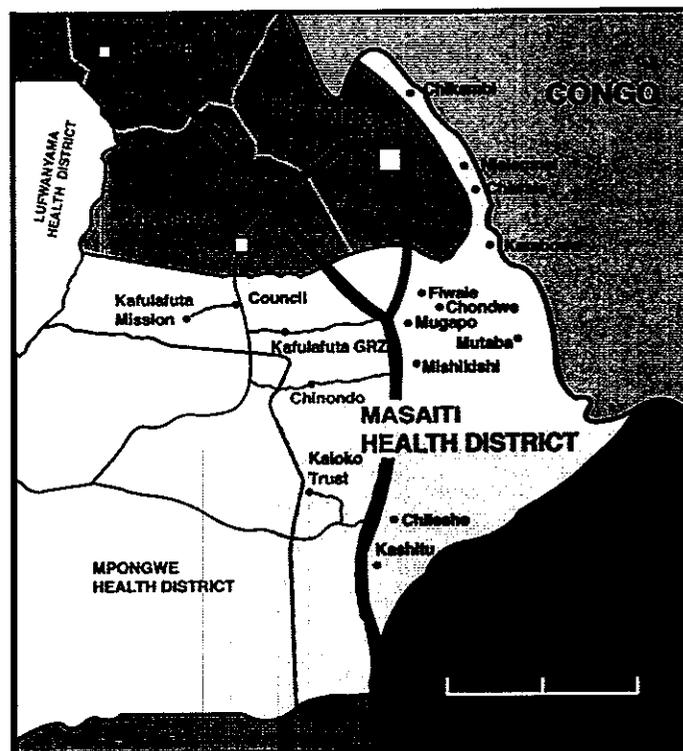
The last three years also witnessed a shift away from what were once pill-dominated method mixes at Council and Kafulafuta Clinics. As was the case at other project sites, exclusive pill use yielded to increases in the use of both injectables and condoms. In fact, Maswana attributed increase in condom use at Council and Kafulafuta Clinics to declines in new STI infections.

¹ Typically, targets are set at 22 percent of all women of reproductive age within a 12 km radius of each service delivery point.

In addition to expanding contraceptive choice, however, Maswana said the ECC Project had contributed significantly to improved provider/client relations; a more reliable flow of supplies and equipment; and increased technical support – particularly from the Project Manager. He also praised the publication of the project newsletter, *Solutions*, which he said had facilitated the exchange of information both within and across Districts.

Mr. Maswana concluded his presentation by highlighting some of the constraints he and his District had faced in implementing the project. Clearly the greatest constraint was the absence of resources that would have made it possible to meet the health needs of those who live far from existing health care facilities. Maswana cited the shortage of health care staff; the absence of community-based distributors (CBD); and a shortage of transport with which health workers might at least travel to those communities accessible by road. Maswana recommended, therefore, that any scaling-up of the ECC project include a concerted effort to reach out to those who have not benefited from the interventions to date. He recommended, for example, greater community involvement, including the hiring and training of CBD agents. He called for providing health workers with bicycles to increase their mobility. And he recommended that the project be extended to the other health centers within his district.

Figure 3
Masaiti District (intervention area at left)



LUFWANYAMA DISTRICT



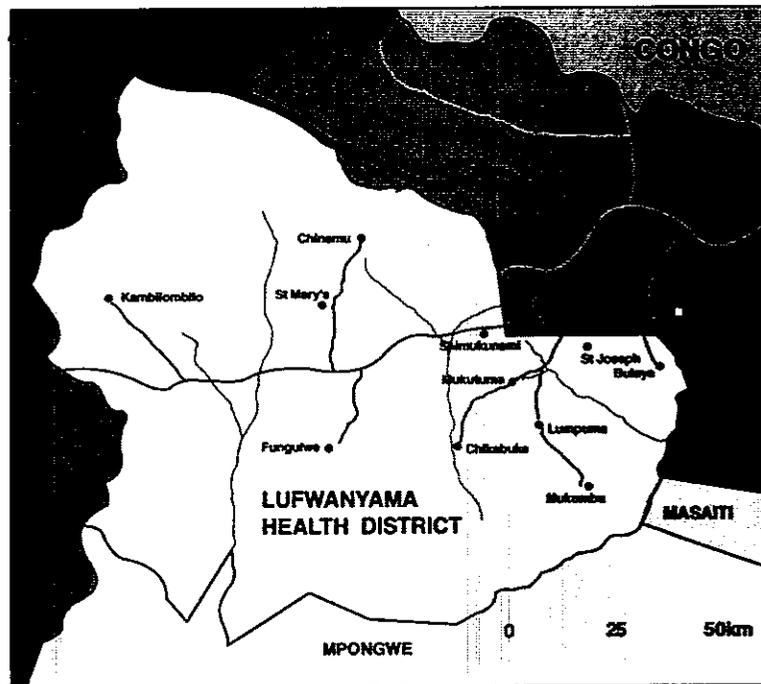
As Director of Lufwanyama DHMT, Mrs. Grace Phiri, began her discussion by thanking those present – especially her District colleagues -- for their hard work in supporting the goals of the ECC Project.

Covering an area of 8.673 km², Lufwanyama is, in geographic terms, the largest health district in Copperbelt Province. It has a total population of 60,715 (CSO 1990); a growth rate of 4.9 percent; and a total fertility rate of 6.2. Like many of the Districts that surround it, Lufwanyama is characterized by high illiteracy (48 percent), a lack of economic infrastructure and employment opportunities. Mobility is high due to

the inflow of retrenched urban workers in search of jobs in the emerald, timber, and agricultural sectors.

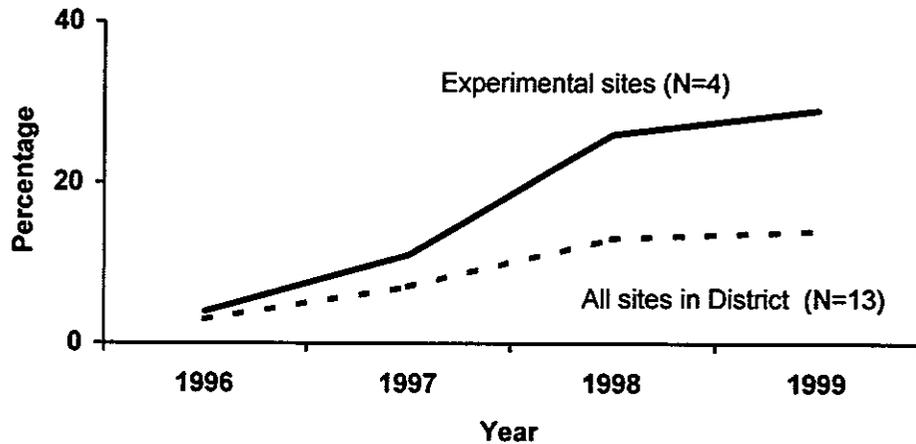
Serving the health needs of the District's growing population are 11 GRZ and two Mission health centers, and seven health posts (see Figure 4). These facilities are supported by 60 trained traditional birth attendants, 57 community health workers, 138 neighborhood health committees, and 38 safe motherhood committees. Because the district has no referral hospital, all complicated maternity cases, serious general cases, and long-term or permanent contraception cases are referred to Kitwe Central Hospital.

Figure 4
Map of Lufwanyama District



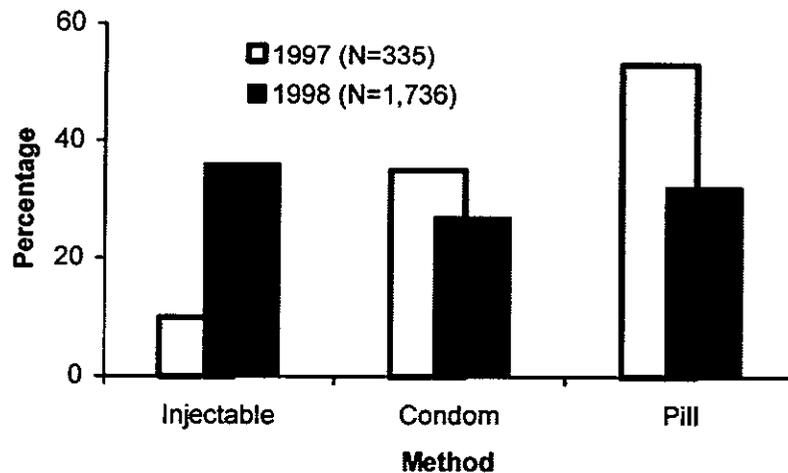
Since the start-up of ECC project activities in 1997, eight of the District's health centers have participated as either control or experimental sites. The four experimental sites: Chati, Chinemu, Kite and Shimukunami benefited early on from the full range of intervention activities. These included provider training; the expansion of method choice, provision of logistics support, and the provision of in-service training in syndromic case management.

Figure 5
New family planning acceptors
as a percentage of acceptor targets



The impact of project interventions on the four control sites was illustrated by Mrs. Phiri in a series of graphs. One compared their performance at achieving acceptor targets compared to District averages (see Figure 5). The second (Figure 6) compared the transition in method mix at the experimental sites before and after project start-up.

Figure 6
Method mix at Lufwanyama District



Finally, Mrs. Phiri pointed to the results of having tracked method preferences by age of the user. She noted, for example, an overall shift in preference from barrier to non-barrier methods as users become older. But even among non-barrier methods, age preferences are evident. The majority of new injectable

users, for example, tended to be less than 26; while the majority of pill users tended to be between 26 and 34 years of age. Few new users of any method were 35 years or above.

Overall, Mrs. Phiri praised the achievements of the ECC Project in Lufwanyama. Specifically, she noted the training of staff; improvements in quality of care; greater method choice; enhanced community and male participation in family planning; and improved logistics and management. Looking towards the future, however, she said her greatest concern was over the issue of sustainability and the need to ensure that the benefits obtained through this project reach all parts of the District. To that end, Phiri recommended that the following interventions be supported under a scaled-up intervention effort.

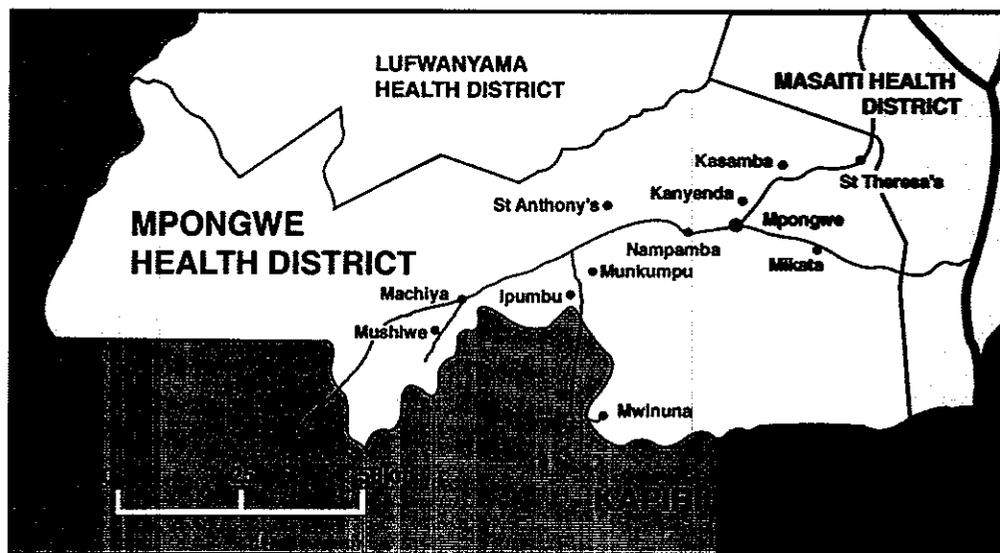
- Train the remaining health personnel in the health centers in family planning provision and especially in counseling
- Maintain community participation by training community based contraceptive distributors, by re-orienting TBAs and CHWs to provide integrated family planning in their services; by strengthening safe motherhood health committees; and by encouraging frequent meetings between rural health center staff and community-based health providers and health promoters.
- Continue quarterly supportive visits and technical support to health center staff, community health providers, and health promoters.

MPONGWE DISTRICT

Rose Munkombwe, Reproductive Health Coordinator at Mpongwe District, summarized her district's involvement in the ECC Project, while at the same time noting many of the constraints and obstacles she and her colleagues encountered along the way.

Mpongwe district is located about 90kms south west of Ndola. With 53,342 (CSO - 1990) inhabitants distributed over approximately 8,000 square kilometers, many inhabitants travel long distances to reach the nearest health facility. The district estimates that between 50 to 40 percent of the population do not have easy access to a health facility.

Figure 7
Map of Mpongwe Rural Health District



In Mpongwe, the ECC Project worked with five health institutions including Kasamba RHC, Mikata RHC, Nampamba Clinic, St. Theresa's and Mpongwe Mission hospital. According to Munkombwe, the impact of the project was evident at all levels. Between 1996 and 2000, for example, district wide family planning coverage increased from 9.1% to 12.9% of married women of reproductive age. The greatest increase was observed during the first three years of project implementation (1997 to 1999).

While many improvements could be attributed to the ECC Project, the message Munkombwe wanted to communicate in her presentation was that conditions had improved throughout the district as a whole. Yes, method choice had expanded in sites that could now offer Depo Provera or emergency contraception; but choice was now also greater at certain control sites. Pill use, for example, which had initially accounted for up to 96 percent of the method mix in Kanyenda had declined to only 38 percent in 2000, the balance falling to condoms (54 percent) and the injectable Noristerate (8 percent). Family planning coverage, though comparatively lower at control sites had nevertheless improved dramatically since the ECC study began.

Admittedly, certain improvements were directly attributable to project interventions. Intervention sites, for example, were consistently better equipped

than their control counterparts – in part because the ECC project had donated over US\$50,000 worth of equipment and supplies to its participating centers.

But for all its accomplishments, the ECC Project also saw its share of difficulties. High staff attrition rates, for example, greatly affected the success of this project as did the lack of a full-time family planning/reproductive health coordinator at the district office. Out of the eleven staff trained in 1997, only three were still active in 2000. The impact of such turnover was made clear in the case of Mikata RHC which, in the first year of the project, saw an eight-fold increase in the number of new family planning acceptors. By late 1997, however, the staff member assigned to the center left and coverage dropped to almost pre-project levels.

Munkombwe concluded her presentation by affirming Mpongwe's commitment to scaling up the project to all centres in the district; to strengthening community based family planning activities; and to integrating the project into district reproductive health services.

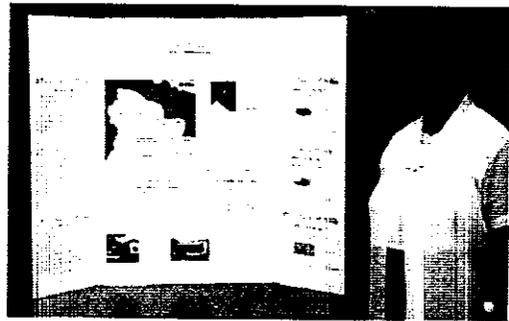
POSTER SESSIONS:

During the lunch break, workshop participants were invited to view seven display tables set up along the sides of the conference hall. Each table was devoted to presenting a critical theme or output described earlier in the day, but in greater depth than would have been possible during an oral presentation. Depending on the subject matter, the displays included maps; posters of key issues and research findings, and a wide range of other publications for distribution. Each table was hosted by an expert who answered questions asked of them by the participants.

The seven display tables covered the following issues:

LUFWANYAMA HEALTH DISTRICT:

This display table provided an overview of the district and its role in the ECC Project. Display materials included a map of all intervention and control sites, photographs, summaries of health indicators, and an evaluation report of the ECC Project's activities, prepared by the Lufwanyama DHMT.

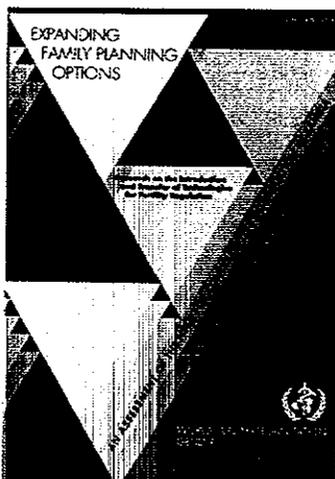


MASAITI HEALTH DISTRICT:

This display table provided an overview of Masaiti District, including a summary of the district's basic health indicators and demographic characteristics. Display materials included two issues of the ECC Project newsletter, *Solutions*, a map of all intervention and control sites, photographs, and an evaluation report of the ECC Project, prepared by the Masaiti DHMT.

MPONGWE HEALTH DISTRICT:

Similar to the displays of the other two participating districts, this table provided basic demographic and health information on Mpongwe and summarized the district's role in the ECC Project. Display materials included a map of all intervention and control sites, photographs, and an evaluation report of the ECC Project, prepared by the Mpongwe DHMT.

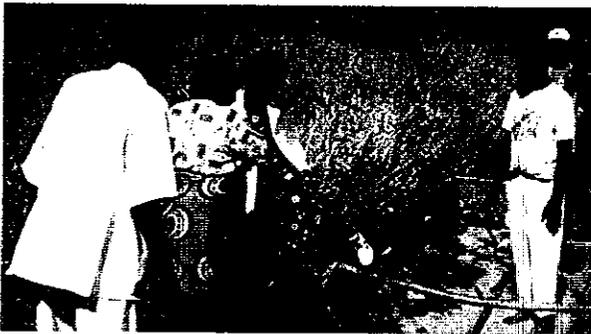
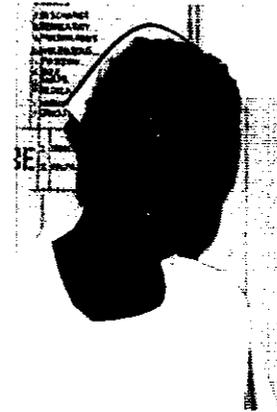


ZAMBIA AND THE WHO STRATEGIC APPROACH:

This table contained a series of materials describing the WHO Strategic Approach; and its application in Zambia. Posters described the findings of the 1995 Zambia Contraceptive Needs Assessment; the rationale behind the Stage II ECC Study; and potential activities under a scaled-up Stage III study. Display materials included copies of the 1995 Zambia Needs Assessment; a series of publications on the WHO Strategic Approach; and copies of the WHO newsletter, *Progress in Human Reproduction Research*.

ON-SITE SELF INSTRUCTIONAL MANUAL:

This table provided workshop participants with more detailed information about the on-site, self-instructional manual, described by Elizabeth Butrick during her earlier presentation. Though still being field-tested, the manual will allow providers to study, at their own pace, the key components of family planning service provision. Lessons are supplemented by readings and by supervisory visits by project and/or DHMT staff. The display table included sample lessons and an array of supplementary readings, including copies of the manual itself.



MEASURING QUALITY OF CARE: SITUATION ANALYSES

1997-2000:

The goal of this table was to highlight the results of a recently completed study, documenting changes in the quality of reproductive health care services over the course of the ECC Project. The study compared, both longitudinally and cross-sectionally,

the results of pre- and post-intervention situation analyses carried out at all of the ECC Project's 21 control and experimental sites. Display materials included a copy of the study report, graphs highlighting key findings of the analysis, and photographs of data collection activities (Present photo shows data collectors crossing the swamps near Mwinuna RHC. 2000 Situation Analysis)

WHAT IMPACT HAS THE ECC STUDY HAD ON THE COMMUNITY?

Ms. Esther Kaputula Sakala, Chairlady of the Community Nutrition Club ;
member of the Kafulafuta Mission Health Neighborhood

Sr. Angela Ikowa, Masaiti DHMT

Mr. Pharaoh Malichanga, Headman of Kapitolo Village, and Chairman
General of the Kasamba RHC Neighborhood Committees

Sr. Rose Munkombwe, Mpongwe DHMT

Mr. Felix Chama, Chairman General, Shimukunami Neighborhood Health
Committee and Headmaster of Shimukunami Basic School

Sr. Violet Mutale, Lufwanyama DHMT

During the morning sessions, project activities and achievements were presented from the perspective of those intimately involved in the study itself - its designers, its managers and indeed its chief proponents. Perhaps because of this, the tone and contents of the presentations were similar: they were technical; they were generally formal; and they were all delivered exclusively in English.

From the outset, a key objective of the ECC Study has been to forge stronger linkages between the District Health centers and the communities served by them. Increases in contraceptive use or changes in method mix, while impressive on paper, mean little if the changes underlying them are imperceptible to the community at large. During the afternoon session, therefore, each of the participating DHMTs invited one community member and service delivery provider to reflect upon changes in the quality of care at the participating clinics and the impact of those changes, if any, on their lives and those around them.

As one might have expected, the discussions were lively, interactive, and often totally unpredictable. Speaking in Lamba through a translator, Ms. Sakala said that the family planning services available at Kafulafuta Mission had not only helped her to keep "clean and smart", but had contributed to improvements in the health of both herself and her children. The ability to limit her family size had enabled her to send her children to school and to contribute better to the economic well-being of the family. Unlike many of her friends, for example, she said she was able to participate in community events and other group activities.

The one weakness in the District's family planning program, she said, was the absence of individuals within the community who could provide contraceptive methods, particularly during the rainy season when the Kafulafuta River floods and cuts off access between her village and the district health centers.

Also speaking in Lamba, Mr. Malichanga of Kapitolo Village described efforts to sensitize his community and local neighborhood committees to the benefits of family planning. He singled out the role of the ECC Project in drawing attention to the concept of "quality" services. As an example, he cited the recognition by residents of Kasamba that their small health center was unable to provide the levels of privacy needed by pregnant women or women in labor. Responding to

this awareness, the community took action. It procured and, in some cases, actually manufactured the materials needed to build a new maternity wing. He appealed for assistance to complete the wing and asked that the ECC Project continue providing the kinds of support he and his community had come to value. As Ms. Sakala had indicated earlier, Mr Malichanga reiterated the need for community based distributors of family planning methods.

Finally, Mr. Felix Chama of Shimukunami praised the ECC Project for having introduced new family planning methods. He also commended the efforts of clinic staff to engage communities through health talks and other neighborhood-based activities. Like the previous speakers, Mr. Chama highlighted the difficulties facing staff in accessing more remote areas. He too emphasized the importance of community based distributors, but also said that providing transport – even bicycles – could help health care workers provide outreach services more effectively and actively.

Though Mr. Chama commended the ECC Project's efforts at expanding contraceptive choice, he recommended that greater attention be paid to the promotion of natural family planning methods – a point on which there was general agreement. He also cautioned against the tendency for some to see "new technologies" as a simple solution to sexual and reproductive health problems. Particularly in the case of young people, he argued, pushing methods without encouraging sexual responsibility is likely to be counter productive and can only lead to a false (and dangerous) sense of security.

Overall, the panelists agreed that the ECC Project had yielded many benefits to their communities. Moreover, all expressed their interest and willingness to participate in scaling-up efforts.

CONCLUSIONS AND RECOMMENDATIONS

Following a tea break, workshop participants reconvened to review the observations, lessons and recommendations of the day's discussions. After a lengthy and often lively discussion, the group unanimously agreed on the following points and recommended that they be formally presented to the Copperbelt Provincial Health Office on behalf of the Zambia Central Board of Health.

- We recommend that the successes of the Enhancing Contraceptive Choice Project be scaled-up into Copperbelt Districts not currently involved in the study; as well as into underserved areas of the three participating Districts.
- We recommend that any efforts to scale-up the ECC Project make provisions for ensuring the long-term financial and operational sustainability of intervention activities;
- We recommend that scaling-up efforts address the acute shortages of health care staff and respond with innovative means for training (such as adoption of the newly developed "self-instructional manual") and performance recognition.
- We recommend that a scaled-up ECC Project maximize community-based linkages for enhancing access to family planning services; for addressing youth concerns; and for strengthening male involvement. Community-based distribution of contraceptive commodities should be an integral part of these community linkages.
- We acknowledge that under the current ECC Project, inadequate transport has been a major constraint to enhancing access. We recommend, therefore, that adequate transport facilities (ie. bicycles) be made available for outreach and other activities.
- We recommend that the resources and competencies of the current ECC Project be utilized as much as possible in preparing for a scaling-up of intervention activities. During the interim period, we recommend that the Central Board of Health authorize continued use of the ECC Project vehicle and other equipment and supplies purchased with WHO funds. We recommend that the Population Council continue providing key project staff with the financial and technical assistance needed to develop a proposal for scaling-up. And we recommend that CARE/Zambia continue supplying current intervention sites with contraceptive commodities (particularly Depo Provera and the female condom) not available through existing public sector logistics systems.
- We acknowledge that there is a demonstrated need and demand for DMPA as well as other new methods such as emergency contraception and female condom. We recommend, therefore, that the CBoH build on existing national policies and ensure that these methods be registered, procured and distributed to health care facilities through routine public sector distribution channels. Should it become necessary within the context of a scaled-up ECC Project, we recommend that the Copperbelt Provincial Health Office assume a key role in the storage and distribution of such new methods
- Finally, we recommend that all Districts involved in a scaled-up ECC Project explore the possibility of collaborating with NGOs, missions, and other institutions providing health care services.

APPENDIX 1: PARTICIPANTS

ENHANCING CONTRACEPTIVE CHOICE AND IMPROVING QUALITY OF CARE PROJECT

DISSEMINATION WORKSHOP, MUKUBA HOTEL, NDOLA, JANUARY 25 AND 26, 2001

LIST OF PARTICIPANTS AND THEIR ADDRESSES

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25	Joan N. Tambo	St. Theresa's Mission Hospital	Box 48, Masaiti, LUANSHYA	
26	Benson Musefwe	Lufwanyama DHMT	Box 22540, KITWE	
27	Ruth Chibale	Lufwanyama DHMT	Box 22540, KITWE	
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30	Pharoh Malichanga	Mpongwe	Box 55, MPONGWE	
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APPENDIX 2: AGENDA

CboH/WHO/USAID/POPULATION COUNCIL

ENHANCING CONTRACEPTIVE CHOICE AND IMPROVING QUALITY OF CARE PROJECT

DISSEMINATION OF RESULTS WORKSHOP JANUARY 25th 2001
MUKUBA HOTEL – NDOLA

AGENDA

WELCOMING REMARKS 9.00 TO 9.30am

Opening speech by Guest of Honour
Introductions
Review of workshop objectives and agenda of activities

OVERVIEW OF ECC PROJECT 9.30 TO 12.30pm

What is the ECC project about and why was it undertaken?

Panel discussants: Peter Hall, Reproductive Health Alliance Europe
Rebecca Kalwani, ZHIP
Monde Luhanga, CboH
Christine Mutungwa, UNICEF
Rose Mulumo, YWCA
Evans Ndalama, Ministry of Health

TEA BREAK 10.15 TO 10.30

What was done and what was achieved?

Panel discussants: Njekwa Lumbwe, CARE/Zambia
Elizabeth Butrick, Population Council
Mary Zama, CboH

What has been the impact of the study and what has been learned?

Panel discussants: Bernard Maswaana, Masaiti DHMT
Grace Phiri, Lufwanyama DHMT
Dr. M. Soko, Mpongwe DHMT
John Skibiak, Population Council

LUNCH BREAK 12.30 TO 14.00

Buffet at Mukuba Hotel Restaurant

You are invited to take a look at our display tables during lunch and tea breaks.
Topics covered by the displays include:

Lufwanyama District
Mpongwe District

Masaiti District
Situation Analysis 1997 – 2000
Self-Directed Learning Manual
WHO Strategic approach to Contraceptive Introduction.

OPEN DISCUSSION BY PROJECT PARTICIPANTS 14.00 to 16.30

Feedback from working groups
Recommendations
Closing remarks 16.30 to 17.00
