

PD-ABE-003

76778

Prepared for

Office of Population
Bureau for Research and Development
Agency for International Development
Washington, D.C.
under Contract No. DPE-3024-Z-00-8078-00
Project No. 936-3024

**EVALUATION OF THE JOHNS HOPKINS
PROGRAM FOR INTERNATIONAL
EDUCATION IN REPRODUCTIVE
HEALTH (JHPIEGO)
BRAZIL COUNTRY STUDY**

by

Karen Johnson Lassner

Fieldwork

April - September 1991

Edited and Produced by

Population Technical Assistance Project
DUAL Incorporated and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: (703) 358-9271

Report No. 90-100-121
Published May 17, 1992

Table of Contents

	Glossary	iii
	Executive Summary	v
1.	Introduction: Historical Overview of JHPIEGO Activities in Brazil	1
2.	JHPIEGO Mandate and Strategy in Brazil	7
	2.1 Country Setting	7
	2.2 JHPIEGO's Brazil Strategy	8
	2.2.1 Influences Shaping JHPIEGO's Strategy	8
	2.2.2 JHPIEGO Strategy in Brazil	9
3.	Project Implementation: Target Institutions	13
	3.1 BEMFAM: Current JHPIEGO Training Model in Brazil — In-Service Training in the Northeast for Integration of Community and Clinical Family Planning Services, Based on Reproductive Risk	13
	3.1.1 Project Evolution	13
	3.1.2 Project Accomplishments	14
	3.1.3 Problem Areas	15
	3.2 CPAIMC: Completed JHPIEGO Model — In-Service Training for Specialist Teams, Primarily to Provide VSC	18
	3.2.1 Project Evolution	18
	3.2.2 Impact and Institutionalization	20
	3.3 Pre-Service Training: Completed JHPIEGO Model — Incorporation of Family Planning into Medical School Curricula	20
	3.4 JHPIEGO Training Model for Brazil under Negotiation: Training of Trainers for Implementation of Public Sector Family Planning Services ..	20
	3.5 Recommended JHPIEGO Strategy for Brazil	21
	3.5.1 Conclusions	21
	3.5.2 Recommendations	22
4.	Training Issues	27
	4.1 JHPIEGO's Technical Performance	27
	4.1.1 Selection Issues	27
	4.1.2 Technical Support in the Field	27
	4.1.3 Field Follow-Up	28
	4.1.4 Monitoring Support	29
	4.1.5 Educational Materials	29

4.1.6	Staffing Constraints	30
4.2	A Training Strategy for Brazil	30
4.2.1	Clinical Staff	30
4.2.2	Non-Clinical Personnel: Team Approach	32
4.3	Training Location	33
5.	Management Issues	37
5.1	Project Staff	37
5.2	Project Planning	37
5.3	Administrative Support	38
5.4	Evaluation	38
5.4.1	Trainee Evaluation	38
5.4.2	Training Evaluation	38
5.4.3	Routine Impact Evaluation	39
5.4.4	Special Impact Evaluations	39
5.4.5	Other Suggested Areas for Evaluation and Information Dissemination	40
5.5	Collaboration with Other Institutions	41
5.5.1	Relationship with In-Country Organizations and Groups	41
5.5.2	Relationship with Implementing Agencies	42
5.5.3	Relationship with Local A.I.D. Representative's Office	42
5.5.4	Relationship with Official Organizations	42
5.5.5	Overlapping Mandates and Relationships with Other A.I.D. CAs	43
5.5.6	Relationship between JHPIEGO and Johns Hopkins University	44

List of Appendices

Appendix A	Assignment Background
Appendix B	Laparoscopy Equipment Maintenance
Appendix C	List of Recommendations

Glossary

ABEPF	Associação Brasileira de Entidades de Planejamento Familiar
A.I.D.	Agency for International Development
APS	Annual Participant Survey
AVSC	Association for Voluntary Surgical Contraception
BEMFAM	Sociedade Civil Bem-Estar Familiar
CA	Cooperating Agency
CBD	community-based distribution
CEPECS	Centro de Estudos e Pesquisas Clovis Salgado
CHW	community health worker
CORSAMI	Coordenação de Saúde Materno-Infantil
CPAIMC	Centro de Pesquisas de Assistência Integrada à Mulher e à Criança
CPR	contraceptive prevalence rate
DA	Development Associates, Inc.
DHS	Demographic and Health Surveys
FEBRASGO	Federação Brasileira de Sociedades de Ginecologia e Obstetria
FHI	Family Health International
FPIA	Family Planning International Assistance
GTI	genital tract infection
IEC	information, education and communication
IPPF	International Planned Parenthood Federation
ISRSM	Instituto de Saúde Reprodutiva de Santa Maria
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU	Johns Hopkins University
LAC	Latin America and the Caribbean
MCH/FP	maternal and child health/family planning
MOEd	Ministry of Education
MOH	Ministry of Health
NGO	non-governmental organization
PAC IIb	Family Planning Training for Paramedical, Auxiliary, and Community IIb (project)
ob/gyns	obstetrician/gynecologists
PAISM	MOH/CORSAMI public sector women's health project
PCS	Population Communication Services (project)
PHC	primary health care
PVO	private voluntary organization
RAM	repair and maintenance
REHEP	Reproductive Health Education Program
RH	reproductive health
SAMEAC	Sociedade de Assistência à Maternidade Escola Assis de Chateaubriand
SBRH	Sociedade Brasileira de Reprodução Humana
STD	sexually transmitted disease
TOT	training of trainers
UNFPA	United Nations Population Fund
VSC	voluntary surgical contraception

Executive Summary

Overview

The Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), with funding from the Agency for International Development (A.I.D.), has been involved in reproductive health training in Brazil through four separate projects since 1979. No new training projects have been initiated since 1984 and the only on-going project is about to be phased out. A fifth new project is now under negotiation. This signals an important change in direction for JHPIEGO, as it is designed solely to train public sector personnel. JHPIEGO's initial program dealt primarily with the private sector and included bringing obstetrician/gynecologists (ob/gyn) to Baltimore, in-service training through two non-governmental organizations (NGO), and pre-service training at selected universities. To date, over 5,000 health professionals (ob/gyns, medical and nursing students, and community health workers) have been trained through JHPIEGO efforts in Brazil.

Strategy

JHPIEGO's planning process has generally been reactive rather than strategic, and the result has been a series of relatively unrelated projects which have not always reinforced one another. JHPIEGO's original emphasis on Baltimore-based training reflected its early approach worldwide: the organization brought leading medical practitioners and administrators to the U.S. in an effort to develop a cadre of influential physicians who would support increased provision of family planning. JHPIEGO's in-country approach — to work solely with private sector NGOs — reflected A.I.D.'s overall pragmatic approach to Cooperating Agency (CA) programming in Brazil, which reflected the paucity of family planning activity in the public sector. Although all in-service training was provided through NGOs, persons trained offered services in all sectors — private practice, private non-profits, and public sector facilities. In accordance with its overall strategy of emphasizing pre-service over in-service training, JHPIEGO also worked with universities to include family planning in medical and nursing school curricula.

JHPIEGO's switch to the public sector reflects three new developments. The most significant was a major reversal in A.I.D. policy toward NGOs, which called for grooming these private non-profits (which A.I.D. had helped develop) for self-sustainability and which was anticipated to lead to termination of support for these key groups (essentially meaning the end of assistance to family planning in Brazil). At the same time, the Ministry of Health began a new effort to train trainers for its women's health care program (including provision of family planning services), and JHPIEGO saw this as an opportunity for a new start in Brazil. This opportunity dovetailed with JHPIEGO's new regional strategy, which is focusing on institutionalization, with emphasis on the public sector.

Impact

JHPIEGO's training of over 5,000 physicians, medical and nursing students, and community health workers over a 12-year period stands as a major accomplishment. In relation to the need in the country, however, the impact must be viewed as less than comprehensive. JHPIEGO has trained probably upwards of 2,000 physicians (primarily ob/gyns); another unknown, but certainly smaller, number of physicians have been trained by the government, other donor agencies, and by

universities providing pre-service training. With some 10,000 ob/gyns in Brazil, clearly additional training could fruitfully be offered to make clinical family planning services more widely available.

Despite its non-strategic approach, JHPIEGO's individual efforts have all had a strong, if limited, impact. In particular, JHPIEGO's assistance to the private non-profit sector has been well placed; this sector has had and will continue to have an important role in institutionalizing the provision of reproductive health services in Brazil.

- **In-service training at CPAIMC (1979-1989)**, a leader in Brazil's private sector family planning movement, 1) made interval voluntary surgical contraception (VSC) services available for the first time in Brazil in both *public and private* institutions and presumably reduced the cesarean rate where serious programs were implemented; 2) extended services to poorer areas of the country; 3) created clinical sites that could be used as training laboratories for other JHPIEGO trainees; and 4) introduced the concept that women should have access to all methods in institutional settings. The project's most important legacy may be the large number of ob/gyns whose training predisposed them to view family planning favorably and whose ranks now include influential full university professors, senior state-level public health officials, and national and state leaders in professional associations of ob/gyn and human reproduction.
- **In-service training at BEMFAM (1984-1991)**, the International Planned Parenthood Federation (IPPF) affiliate in Brazil, increased and improved the quality of services in the public sector, both those provided by physicians and those offered by community health workers (CHW), who learned how to refer high-risk clients. Moreover, JHPIEGO's work has made important contributions by meeting the needs of poorer sectors of the country (the Northeast), by providing a full range of methods in institutional settings, and by integrating family planning into maternal and child health (MCH) services. JHPIEGO's efforts have also given BEMFAM credibility, have helped provide structure to the jobs of the CHWs, and have helped integrate what was formerly a community-based family planning program into the public sector in the two Northeastern states where the project is operational. Finally, JHPIEGO training, through BEMFAM, predisposed influential ob/gyns toward family planning: many are now called upon by state and federal governments to help shape family planning policy in Brazil.
- **The pre-service training (1981-1986)**, which was offered to medical and nursing students at three university-affiliated training centers, resulted in these schools having curricula that include reproductive health; still, the proportion of all schools in Brazil with family planning in their curricula is very small and thus very few health personnel begin their practice with any knowledge of family planning.

One area of need not addressed to date by JHPIEGO is training of non-medical staff (social workers, psychologists, and social scientists), although they are integral parts of multi-disciplinary teams at medical facilities and often refer clients to family planning services.

Current Programming Issues

Needs. The need is considerable in Brazil for improving the method mix and increasing availability of both services and training in the public sector. Even though the contraceptive prevalence rate (CPR) is estimated at 66 percent (including 56 percent modern methods), Brazilian women rely primarily on two methods — the pill and female sterilization, the latter most frequently performed in conjunction with cesarean section. Family planning services in Brazil are provided almost exclusively through the private sector — NGOs including BEMFAM, CPAIMC and its offshoot, ABEPF; through private physicians; and through pharmacies. Most public health services lack family planning commodities, as public revenues have not been allocated to purchase them. Likewise, almost all reproductive health training in medical and nursing schools has been provided through private sector, university-affiliated institutions.

Constraints. Making inroads in this situation is very difficult in Brazil. Although on paper, public policies are largely favorable toward family planning, the reality is that the climate is much less so, especially for clinical methods. All first-time family planning users, including those of oral contraceptives, must have a complete physical before they can be provided a method. Before an IUD can be inserted, the results of a recent Pap smear must be presented in order to identify both cervical cancer and genital tract infections (a particular problem where there is no laboratory backup). Sterilizations, covertly provided now, may become illegal if current efforts to enact legislation to this effect succeed. Parliamentary inquiries regarding the status of VSC activities at NGOs have already forced BEMFAM to discontinue provision of sterilization at its clinic in Pernambuco and referral for VSC at all other BEMFAM service sites.

JHPIEGO's Position. The difficult situation with regard to VSC has resulted in JHPIEGO's attempting to distance itself somewhat from its association with the method, attempting to project instead an image of an organization that is primarily concerned with reproductive health. Because it has, in fact, focused on clinical training in laparoscopy and provided laparoscopes (which have been highly valued by the medical establishment), JHPIEGO remains closely linked in most organizations' minds with sterilization. CPAIMC, in particular, feels it has paid a very high price in terms of its own public image for the pioneering work in VSC it carried out as a result of JHPIEGO training and now feels somewhat isolated as — in response to A.I.D.'s instructions to promote NGO self-sufficiency — JHPIEGO has withdrawn its support.

Management and Technical Support Issues

JHPIEGO has consistently provided solid administrative support to its projects in Brazil. Project proposals are written clearly, funds arrive on time, and financial arrangements work smoothly. Organizations commented particularly on the large effort expended by JHPIEGO staff to monitor projects.

In its planning for project implementation, JHPIEGO has not always considered all contingencies. For example, it has not always adequately assessed institutional capacity to execute project activities nor has it taken into account project developments that would suggest changes in project design. The explanation probably lies primarily with JHPIEGO's management arrangements, which rely on a very small staff at Baltimore headquarters to plan and backstop all its Latin American programs.

Lack of sufficient headquarters staff is also probably the main explanation for deficiencies in JHPIEGO's technical support. JHPIEGO projects have received inadequate technical assistance in a number of areas — curriculum development, teaching skills, clinical backup during training, and follow-up to support trainees, once they have returned to their jobs. Both BEMFAM and CPAIMC training staff could have benefited from JHPIEGO-assisted training of trainers. Because of the high level of technical skills of local project directors, the lack of technical backup has not had serious medical consequences. JHPIEGO has plans to increase its support by hiring local consultants.

JHPIEGO routinely follows up trainees through Annual Participant Surveys, but these are of questionable value. Far more promising is a special impact evaluation of the BEMFAM project, which should throw light on the long-term impact, quality, and performance of this effort.

JHPIEGO has not developed strong ties with professional medical groups in Brazil, nor has it done as good a job as it might have in cultivating its ties with its own alumni. On the other hand, as it plans its new public sector project, it is beginning to make contact with various parts of the Ministry of Health.

JHPIEGO's mandate overlaps those of three other CAs — Development Associates (DA), the Pathfinder Fund, and the Association for Voluntary Surgical Contraception (AVSC). This overlap has advantages, as it allows CAs flexibility. Problems have arisen only when the CAs have given insufficient attention to coordinating their activities.

Recommendations

JHPIEGO should consider broadening its approach in Brazil to include not only the new program with the government, but also to reactivating two other efforts, pre-service training and the BEMFAM project. Priority should be assigned as follows:

- Efforts should be resumed to institutionalize pre-service training in schools of medicine, nursing, and social work. JHPIEGO should coordinate its efforts with other CAs, particularly Pathfinder. Priority should be placed upon including reproductive health in the curricula of schools of medicine, nursing, and social work.
- JHPIEGO should continue its efforts to initiate training assistance for the public sector women's health care program, specifically training of trainers at MOH-designated training centers.
- JHPIEGO should continue to support private sector family planning training, particularly for the BEMFAM program and its expansion to five remaining Northeast states where JHPIEGO has not previously provided training support.

A complete list of recommendations is provided in Appendix C of this report.

- 1. Introduction: Historical Overview
of JHPIEGO Activities in Brazil**

1. Introduction: Historical Overview of JHPIEGO Activities in Brazil

The Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), an Agency of International Development (A.I.D.) program, has been involved in reproductive health training in Brazil through four separate projects since 1979. No new training projects have been initiated since 1984, however, and the only on-going project is about to be phased out. A fifth new project is under negotiation. JHPIEGO's initial approach consisted of a combination of in-service training for the private sector and pre-service training at selected universities. The only current program is a private sector in-service training effort, focusing on integration of statewide community family planning programs with local clinical services (the BEMFAM [Sociedade Civil Bem-Estar Familiar] project). The project now being negotiated signals an important change in direction, as it is designed solely to train public sector personnel.

To date, over 5,000 health professionals have been trained through JHPIEGO efforts in Brazil.

In chronological order, the four projects implemented to date and the fifth project under negotiation are as follows:

- **In-Service Training at JHPIEGO/Baltimore**

In 1979 and several years following, Brazil's leading obstetrician/gynecologists (ob/gyns) and specialists in human reproduction participated in JHPIEGO's Baltimore-based reproductive health training courses. Following didactic training in Baltimore, the majority participated in practice training in laparoscopy in JHPIEGO training programs outside the United States. Participation in the courses entitled the participants, many of whom were university professors, to receive laparoscopic equipment donated by JHPIEGO (see Appendix B for a discussion of laparoscopic equipment).

Over the course of this project, a total of 219 health professionals received training, including 109 medical administrators and 110 physicians who received instruction in reproductive health skills including laparoscopy and sexually transmitted diseases (STD).¹

- **In-Service Training at CPAIMC (Centro de Pesquisas de Assistencia Integrada a Mulher e a Crianca), with Emphasis on Voluntary Surgical Contraception (VSC)**

This project operated from 1979 to 1989 and provided in-country, in-service reproductive health training through the non-governmental organization (NGO) CPAIMC, a leader in Brazil's family planning movement and, in 1979, one of the few maternal and child health/family planning (MCH/FP) organizations in Brazil that provided VSC services. The training focused on a team approach and included surgeons, nursing personnel, and anesthesiologists who would operate together to perform laparoscopic or minilaparotomy services for those who wished tubal ligation.

¹Figures from JHPIEGO headquarters. The figures below for the other three projects are from Brazil and reflect planned numbers, rather than actual participants.

Although the full range of reproductive health training was provided, the emphasis was on VSC, first through laparoscopy and then, when it was ascertained that approximately half the national need for laparoscopy training had been satisfied, through minilaparotomy. The switch in 1984 to minilap was not popular with physicians, who found the laparoscope valuable for not only VSC but for diagnosis of various reproductive health problems. This change in emphasis, together with a reduction in A.I.D. support for both policy and management reasons, led to the project's gradually being phased out.

In 1987 and 1989, while the program was being reduced in scope, CPAIMC trained 18 university professors in reproductive health educational technology in two five-day seminars. During the first seminar, a model curriculum was developed for teaching of reproductive health in medical schools which was to be presented to the Ministry of Education (MOEd). The initiative, however, lacked follow-up and the impact of the training has not been formally evaluated.

During the 10 years of support to CPAIMC, 600 Brazilian physicians, 125 anesthesiologists and 350 nurses and auxiliaries were trained in family planning. In addition, more than 300 laparoscopic systems were distributed. In 1979, JHPIEGO signed a repair and maintenance (RAM) contract with CPAIMC.

- **In-Service Training at BEMFAM for Integration of Community-Based and Clinical Family Planning Services**

This project has been operating since 1984 and is scheduled to be phased out in 1991. It involves support to the NGO BEMFAM, the International Planned Parenthood Federation (IPPF) affiliate in Brazil, to train physicians and community health workers (CHW) to provide services in integrated, state-wide community and clinical family planning programs in three high-priority states. The project was initiated in Pernambuco in 1984, in Rio de Janeiro in 1985, and in Ceará in 1989. The objective of the project is to integrate BEMFAM's community program with clinical family planning services (primarily public sector) by using a reproductive risk classification and referral system.

Since project initiation, nearly 300 physicians and 1,000 CHWs have been trained.

- **Pre-Service Training at Universities**

This project, called the Reproductive Health Education Program (REHEP), operated between 1981 and 1986 and involved support for pre-service training for medical and nursing students at three university-affiliated training centers: the Assis Chateaubriand Maternity Hospital (SAMEAC) of the Federal University of Ceará in Fortaleza; CEPECS (Centro de Estudos e Pesquisas Clovis Salgado), affiliated with the Federal University of Minas Gerais in Belo Horizonte; and ISRSM (Instituto de Saude Reprodutiva de Santa Maria), affiliated with the Federal University of Santa Maria in the state of Rio Grande do Sul.

A total of 1,240 medical students and 550 nursing students received theoretical training in family planning through this project.

- **Training of Trainers for the Public Sector Women's Health Care Program, PAISM (currently under negotiation)**

JHPIEGO is currently negotiating a project with CORSAMI (Coordenação de Saúde Materno-Infantil), the MCH division of the Ministry of Health (MOH), to train trainers for the women's health care program operated by the Ministry of Health. PAISM, as the program is called, provides a wide range of services (gynecology, prenatal care, cancer detection, sexually transmitted diseases [STD], infertility and contraceptive services) in health centers nationwide, but particularly in the Northeast. The JHPIEGO-trained trainers, who will be from PAISM state training centers, will provide in-service training for public sector service providers. United Nations Population Fund (UNFPA), World Bank (Northeast Project), and other MOH funds will be used to cover participant travel and per diem costs.

2. JHPIEGO Mandate and Strategy in Brazil

2. JHPIEGO Mandate and Strategy in Brazil

2.1 Country Setting

Brazil is ranked by A.I.D. as an advanced developing country and its contraceptive prevalence rate (CPR) is high: in 1986, the CPR was 66 percent and it is now estimated at 70 percent or more. Of the 66 percent in 1986, about 56 percent of women used modern methods and 10 percent traditional methods.² Brazilian women, however, rely heavily on two methods — the pill and female sterilization account for 79 percent of the CPR. Sterilization is most frequently performed in conjunction with cesarean section: 72 percent of all sterilized women whose last birth occurred in a hospital were sterilized concomitant with cesarean sections. Thus, one of Brazil's greatest training needs is in both post-partum and interval minilaparotomy in order to reduce medically unnecessary cesarean sections and provide other opportunities to obtain VSC services in addition to those provided at the time of pregnancy/delivery. In 1986, prevalence of intrauterine devices (IUD) was less than 1 percent. Oral contraceptives are almost exclusively obtained in the commercial sector: 93 percent of all women who use oral contraceptives purchase them in pharmacies. The result is that the majority of women do not take pills correctly and that there is a high drop-out rate and low use effectiveness. In spite of relatively high contraceptive prevalence, induced abortion and adolescent fertility rates are high.

Table 1

Percentage of Currently Married Women, Aged 15-44,
Using Contraception, by Method: Brazil, 1986

Method	% Using
Female sterilization	26.9
Orals	25.2
Withdrawal	5.0
Periodic abstinence*	4.3
Condom	1.7
Male sterilization	.8
Others**	2.0
All methods	65.9

*rhythm, Billings

**IUD, injectables, diaphragm and vaginal methods

Family planning services in Brazil are provided almost exclusively through the private sector — NGOs including BEMFAM, CPAIMC, and ABEPF (Associação Brasileira de Entidades de Planejamento Familiar (see Chapter 3 below), private physicians, and pharmacies. Likewise, almost

²Population Reference Bureau, World Population Data Sheet, 1991.

all reproductive health training in medical and nursing schools has been provided through private sector, university-affiliated institutions.

On paper, public policies in Brazil are largely favorable toward family planning. PAISM, created in 1984, includes provision of family planning services. The most recent constitution (1989) also guarantees the right to receive family planning information and services. In practice, however, a variety of barriers inhibit use of most methods. For example, the majority of public health services lack family planning commodities, as public revenues have not been allocated to purchase them. Also, all first-time family planning users, including those of oral contraceptives, must have a complete physical before they can be provided a method. Another MOH regulation requires that the results of a recent Pap smear be presented in order to identify both cervical cancer and genital tract infections (GTI) before an IUD can be inserted. This is a particular problem in the Northeast, since the majority of clinics do not have cytology or other types of laboratory backup. In order to insert IUDs without laboratory backup, physicians should rely on their clinical skills for GTI identification and management but cannot do so due to lack of training. The absence of laboratory backup has thus become an important barrier to IUD service provision, indicating the need to train physicians in GTI identification and management in order to give them the confidence and expertise necessary to provide IUD services. With respect to sterilization, in part because of the high incidence of sterilizations concomitant with cesarean sections, efforts are now under way to enact legislation that would make all sterilizations illegal. To some degree, this is already the case: VSCs are allowed only in "special circumstances." The new approach, however, would tighten enforcement of this requirement. Parliamentary inquiries regarding the status of VSC activities at NGOs have already forced BEMFAM to discontinue provision of sterilization at its clinic in Pernambuco and referral for VSC at all other BEMFAM service sites.

2.2 JHPIEGO's Brazil Strategy

2.2.1 Influences Shaping JHPIEGO's Strategy

JHPIEGO's country strategy for Brazil takes into account three types of mandates: JHPIEGO's own project strategy; JHPIEGO's regional strategy; and A.I.D.'s strategy for Brazil. These are set forth below:

- **JHPIEGO's Overall Strategy.** JHPIEGO's purpose, as stated in its cooperative agreement with A.I.D., is to increase the availability of improved reproductive health measures and the number of developing country health professionals with knowledge and skills in reproductive health, especially family planning. The project's objectives include
 - increasing training capability in modern methods;
 - promoting pre-service training over in-service training; and
 - exploring new teaching technologies.
- **JHPIEGO's Regional Strategy.** In Latin America, the JHPIEGO regional training strategy includes
 - greater focus on reproductive health training as opposed to surgical training;
 - emphasis on reproductive risk;

- institutionalization of training capabilities, with particular emphasis on the public sector, and development of multiple, regional in-country training sites;
 - increased clinical training in IUD management; and
 - emphasis on developing family planning infrastructure, as opposed to pre- or in-service training or post-graduate training.
- **A.I.D.'s Brazil Strategy.** A.I.D.'s current strategy for Brazil grew out of a 1987 A.I.D. evaluation of population assistance to Brazil and takes into account the current constraints to service delivery and the need to develop more sustainable services (assuming gradual withdrawal of A.I.D. funds). As described in JHPIEGO's annual workplan for program year 5, it recommends that A.I.D. Cooperating Agencies (CA) should direct their support to
 - increasing access to family planning services of underserved areas and populations (the Northeast region, Minas Gerais, slum populations around Rio de Janeiro, men, and young adults);
 - supporting policy and program changes (research on constraints to service; information programs; offering a wider range of methods) to improve quality of services; and
 - promoting sustainable programs (improving linkages between private and government programs; increased local support; focused program strategies, etc.).

2.2.2 JHPIEGO Strategy in Brazil

JHPIEGO's original emphasis on Baltimore-based training reflected its early approach worldwide: the organization brought leading medical practitioners and administrators to the U.S. in an effort to develop a cadre of influential physicians who would support increased provision of family planning. At the same time, JHPIEGO's in-country approach — to work solely with private sector NGOs — reflected A.I.D.'s overall approach to CA programming in Brazil. Given the paucity of activity in the public sector, A.I.D. was urging its CAs to put their resources into the prime NGOs that were providing family planning. Thus, all in-service training was provided through NGO organizations, although persons trained may have offered services in public sector facilities. In accordance with its strategy of emphasizing pre-service over in-service training, JHPIEGO also made an effort to work with universities in order to include family planning in medical and nursing school curricula.

For a number of reasons, primarily A.I.D.'s policy change that emphasized grooming NGOs for self-sustainability, programming in the NGO sector has become increasingly difficult. At the same time, an opportunity has arisen that would allow JHPIEGO to assist the public sector in training staff to provide family planning services through public sector facilities nationwide. Thus, JHPIEGO's strategy in Brazil is now in transition, poised for a new start that JHPIEGO hopes will have a long-term impact on the reproductive health care delivery system in the country.

Over the years, JHPIEGO has projected two images in Brazil. It has made strong efforts to establish itself as an organization concerned primarily with reproductive health, as opposed to simply provision of family planning. At the same time, because it has focused on clinical training in laparoscopy and provided laparoscopes (which have been highly valued by the medical establishment), its image has to some degree become identified with sterilization. Partly as a result,

JHPIEGO's purpose and objectives are not well understood by Brazilian institutions, the government (particularly by CORSAMI/MOH staff), or by international organizations. All institutions recognize that JHPIEGO's primary objective is training. Those institutions that receive support from JHPIEGO identify their particular training-project objectives as being JHPIEGO's objectives. To some national organizations, the training emphasis is seen as VSC. To others, physician training in contraception is viewed as JHPIEGO's main objective.

To date, the private sector and international organizations have been more receptive to the advantages and benefits of working with JHPIEGO than has the public sector, which continues to have reservations about its prospective involvement with JHPIEGO.

3. Project Implementation: Target Institutions

3. Project Implementation: Target Institutions

3.1 BEMFAM: Current JHPIEGO Training Model in Brazil – In-Service Training in the Northeast for Integration of Community and Clinical Family Planning Services, Based on Reproductive Risk

3.1.1 Project Evolution

Original Design

JHPIEGO's initial objective in providing assistance to BEMFAM was to help that organization strengthen its community-based distribution (CBD) programs by linking them to clinical services programs. BEMFAM had initiated statewide CBD family planning programs in the Northeast, Brazil's poorest region, in the mid-1970s. The project design involved training CBD workers to classify clients according to their reproductive risks and to refer medium- and high-risk clients, or those for whom the desired contraceptive was contraindicated, to physicians in municipal clinics. High-risk women were defined in terms of age (too young or too old), high parity, and spacing of their children (under two years), as well as those having had problem obstetrical histories.

JHPIEGO also assisted BEMFAM with training of the physicians to whom the high-risk women were referred. Physician training included both the reproductive risk concept and clinical and surgical contraception, with emphasis on practice training in IUD management and minilaparotomy. Like the CHWs, the doctors were not BEMFAM employees but rather healthcare providers employed by municipal governments, and the services they provided were through local public health facilities.

Thus, the significance of the reproductive risk classification and referral system for the BEMFAM project was that it provided BEMFAM with a tool to integrate its CBD program into local health services.

Project Redesign to Conform to Government Policy

In 1987, a PAISM family planning service norm was issued by the MOH, which required *all* clients seeking oral contraceptives, IUDs, and sterilization to be seen initially by a physician before a contraceptive could be dispensed. Consequently, BEMFAM changed its policy for its community-based projects to be in accord with that of the government.

Although the change in the BEMFAM contraceptive supply policy occurred three to four years ago, BEMFAM and JHPIEGO have not yet fully adapted the training program to the new service policy. BEMFAM continues to train physicians and CHWs in the concept of reproductive risk and its classification; risk classification has been simplified to include only two categories (at-risk or not-at-risk). Training continues to emphasize that women classified as being at-risk should be counseled to use the most effective methods. On the other hand, the referral of clients to physicians according to their risk classification is no longer included in training, since due to the new policy, all women are referred to physicians independent of their risk classification. In the near future, it is highly unlikely that BEMFAM will re-initiate referral of only at-risk women to the physician since to do so would be inconsistent with MOH norms.

Continuing to emphasize reproductive risk classification in BEMFAM training has not been entirely helpful, in terms of service delivery efforts of both BEMFAM CHWs and physicians. CHWs continue to spend nearly 100 percent of their time on client interviewing and data collection for purposes of risk classification, only to have the same data collected again by the physicians, since all clients are seen by physicians. Not only is this a wasteful duplication of effort, but it also leaves almost no time for CHWs to inform and counsel clients, two far more important functions within the current context of BEMFAM services. It would have been better if the training and service program had been adapted to have given much greater emphasis to CHW information, education and communication (IEC) activities, rather than continuing to emphasize CHW reproductive risk classification.

Recent Development

JHPIEGO has recently been phasing out of CHW training in order to comply more closely with its mandate, which distinguishes between the roles of Development Associates (DA) and JHPIEGO. Under the Family Planning Training for Paramedical, Auxiliary, and Community (PAC) IIb project, DA is charged with training of field-level workers, whereas JHPIEGO's mandate is to train physicians, nurses, and midwives. At the time of the evaluation, JHPIEGO was supporting only physician training in Rio de Janeiro and Pernambuco and intends to stop training CHWs in Ceará in the near future.

3.1.2 Project Accomplishments

Improvement of Service Provision

Institutionally, JHPIEGO-supported training has had a profound effect on the BEMFAM service delivery model. In municipalities in which BEMFAM has integrated its CBD program with clinical services, the quality of services has improved significantly. Specifically, the array of contraceptive information and services provided by BEMFAM has been expanded to include not only orals, condoms, and spermicides, but also IUDs, diaphragms, and VSC (generally, a full range of methods is offered only in the private sector). Moreover, family planning has been introduced into the health sector as a health service — specifically as a component of MCH care. Women who were former clients of the CBD program have also acquired access to gynecological services, particularly cervical cancer detection, which were previously unavailable in conjunction with family planning. For many BEMFAM clients, the new service model has provided access to Pap smear services for the first time.

In addition, this effort has provided service to needy groups such as low-income women living in *favelas* in Rio de Janeiro, low-income women in the poor states of the Northeast, adolescents, prostitutes, military recruits, and other underserved populations. These service programs have sometimes served as training laboratories for JHPIEGO trainees (with the expectation that similar programs will be initiated by trainees at their home institutions).

Better Structure for CHW Activities

Early on, reproductive risk classification proved to be an important tool in providing structure to the work of CHWs and in helping them to understand better the importance of family planning.

Increased Credibility for BEMFAM

The new service model has contributed to creating a more positive image of BEMFAM throughout the country. The project has served to stifle criticism from family planning opponents that BEMFAM's CBD services were not provided within the context of health service delivery and that they lacked medical backup. Not only do BEMFAM staff now have greater confidence in their program; because it is integrated with the formal health system, they can also more easily promote its service model.

This improved institutional image should contribute to greater social acceptability for family planning and more opportunity for BEMFAM to participate in shaping public policy regarding family planning. Consequently, in the long run, the new service model should enable BEMFAM to achieve its objective more easily — that of stimulating implementation of a national family planning program.

Institutionalization: Incorporation of CBD Effort into Formal Health Sector

The most significant contribution of BEMFAM's current service model is that it has served to integrate what was formerly a community-based family planning program into the public sector in the two Northeastern states where the project is operational. It is thus providing family planning services in government facilities where they have not previously been available. In the two Northeastern states — Pernambuco and Ceará — where the majority of BEMFAM service sites are located, family planning services are now available in municipal health facilities (hospitals, health centers, and health posts). This development has placed BEMFAM in a position to assist the public sector with implementation of the family planning component of PAISM. Since BEMFAM's new service delivery norms are very similar to those of PAISM, municipal governments turn to BEMFAM for technical and material assistance in implementing PAISM.

3.1.3 Problem Areas

The project has not been entirely successful, with problems including some inconvenience to clients, little expansion of the method mix, confusion with respect to anesthesia procedures for VSC, and limited long-term institutionalization. Many of these problems, however, are attributable to the difficult family planning climate in Brazil, where constraints to training and service delivery include negative attitudes toward both IUDs and minilaparotomy, MOH regulations with regard to IUDs, and lack of clients for clinical practicum for IUD insertion.

Weaknesses in Performance

Inconvenience to Clients. Although for some clients, the new BEMFAM service model has meant a great improvement in the quality of health care, for others, integration of CBD services within the public sector has represented an inconvenience. In the CBD program, oral contraceptives could be obtained after only a short visit with the BEMFAM distributor. In the new service delivery model, long waiting lines are formed early in the morning at public health posts for those who wish to see a physician.

Little Improvement in Method Mix. With respect to use of IUDs, the BEMFAM service model does not appear to have had a significant impact in the three state programs where the project was implemented. Data collected for a sample of BEMFAM posts revealed that the mean number of IUD insertions per month was less than .5 per post following training in Rio de Janeiro and Ceará³ (although it may be too early to evaluate results in Ceará). In Pernambuco, a mean of 1.9 insertions were performed per post in April 1991 after training, compared with .2 IUDs per post per month in 1984 (prior to training). Whether the project has widened access to **minilaparotomy** is unknown. At the time of data collection for this report, physicians associated with the project in Fortaleza and Rio de Janeiro had no facilities of their own in which to provide VSC services and nowhere to refer clients for services.

Inappropriate Techniques for Anesthesia. Technically, training in anesthesia for minilaparotomy has not always been in accord with JHPIEGO's medical guidelines. The standard JHPIEGO-recommended practice is local anesthesia with sedation. In Pernambuco, however, all physicians were trained in another technique referred to locally as a "mini-spinal block."

In Ceará, although physicians were trained in the standard procedure (local anesthesia with sedation) at the university maternity hospital, epidural anesthesia is the technique of choice at the hospital when physicians are not in training, which undermines the credibility of local anesthesia for VSC. Also, infection prevention has not received sufficient attention in the curriculum either in Ceará and Pernambuco.

Institutionalization Only Partially Realized. In-service training is being institutionalized at BEMFAM to a far greater degree than at CPAIMC and the other JHPIEGO training centers. Turnover, however, has cut into the long-term impact of the effort. Because the CHWs and physicians trained by the project are not BEMFAM employees but rather health providers employed by municipal governments, they are rotated frequently, depending on the political whims of municipal secretariats of health staff. The problem has become particularly acute following municipal elections and designation of new secretaries of health. In Pernambuco, for example, a total of 169 physicians and 542 CHWs have been trained, sufficient to have at least one trained team in every municipality in the state. Due to staff turnover, however, in 1991 the reproductive risk service model was in operation in only 89 of 167 municipalities.

With respect to the phasing out of JHPIEGO support, BEMFAM has been seeking funding from local governments to cover the costs of training its own CHWs and physicians. The effort has been partially successful for CHW training, in particular because of its low cost. More costly physician training, on the other hand, has not been as easily institutionalized.

In-Country Constraints

IUDs. The difficult climate in Brazil for family planning — and particularly for IUDs and minilaparotomy — explains in large measure why it has not been possible to improve the method mix through the BEMFAM project.

³In Rio de Janeiro the mean number of monthly IUD insertions prior to implementation of the training project was .2 per post, compared to .3 per post following training. In Ceará, the number of monthly IUD insertions prior to training was less than .1; following training, the mean number of IUD insertions was .2.

With respect to IUDs, although the JHPIEGO training effort should have helped to make IUDs available, other factors have continued to inhibit their use. Some of BEMFAM's own service providers have negative attitudes toward this method, making it unlikely that the public-at-large will overcome its skepticism. The government regulation requiring Pap smears prior to the insertion serves to compound the problem (see Section 2.1), particularly in the Northeast, where few clinics have cytology laboratory backup. Most important, women also know little about the IUD. What information they do have has been negatively influenced by reporting by the mass media, particularly television, and the problems involving the Dalkon Shield. The situation points to a great need for a large IEC campaign regarding IUDs, particularly in the Northeast, directed both to health providers and to potential clients.

This low acceptance of IUDs by clients and providers has hampered JHPIEGO's training efforts: JHPIEGO requires that 10 IUD insertions be performed in order to achieve competency but BEMFAM clinics have difficulty in obtaining this number of clients. In 1990, for example, the mean monthly number of IUD insertions per BEMFAM clinic in Rio de Janeiro, Pernambuco, and Ceará was 48, 7, and 4 respectively. In Ceará, the project was originally designed to train physicians in IUD insertion at BEMFAM clinics. These clinics, however, were inserting an annual combined total of only 40 IUDs in two clinics, an insufficient number to train 10 programmed physicians. Thus, the originally scheduled IUD training had to be transferred to SAMEAC where ample opportunity exists to train in IUD insertion. In Pernambuco, clients' menstrual cycles are regulated with oral contraceptives to induce menstruation during training weeks in order to ensure sufficient IUD insertion cases. In Rio de Janeiro, a physician had observed only two IUD insertions as of the third day of a five-day training program in which he was expected to perform 10 insertions to achieve competency. JHPIEGO is addressing this problem, which is common throughout the countries in which it works, by promoting use of a pelvic model designed for practice training in IUD insertion. Use of the model is believed to reduce to 2 or 3 the number of insertions in human beings needed to achieve competency.

VSC. The situation with regard to VSC is comparable to that for IUDs, with BEMFAM staff at the state levels demonstrating somewhat negative attitudes toward this method. VSC services are currently in a state of flux at BEMFAM. Since early 1991, none of the service sites visited in the cities of Fortaleza and Rio de Janeiro has referred clients requesting VSC. The parliamentary inquiries under way regarding the status of VSC activities at NGOs also forced BEMFAM in early 1991 to discontinue provision of VSC services at its own clinic in Pernambuco.

Need for Stronger Medical Leadership. Most of the problems described above reflect the absence of strong medical leadership on the part of BEMFAM at the state level. This is not to say that BEMFAM's own physicians are technically weak, but instead that the medical components of both the training and service program require stronger supervision.

From the standpoint of supervising CHW activities, BEMFAM's monitoring of the project is satisfactory. In accordance with its routine CBD supervisory system, regional supervisors periodically provide on-site training and re-training for CHWs, verify data collection procedures, perform IEC activities, and make community contacts. Their efforts are supplemented by a special supervisor who oversees implementation of the reproductive risk project throughout the state.

On the other hand, supervision of the process of integration of clinical services is deficient. The physicians are not adequately supported and supervised. BEMFAM and JHPIEGO have assigned the responsibility of physician supervision to BEMFAM's medical director, who, located

in Rio de Janeiro, is too distant from the field (particularly the Northeastern states) to supervise physician services effectively. Furthermore, supervision of physicians and CHWs as teams is lacking. As a result, the CHW and physician do not know each other's capabilities and often do not understand each other's functions. Such a climate is not propitious to delegation of the reproductive risk classification and referral function to the CHW nor to effective teamwork.

As the training institution that helped set this new model in motion, JHPIEGO may bear some responsibility for these deficits. With more effective assistance, JHPIEGO might have been more successful in preparing BEMFAM to integrate its community family planning program into municipal health facilities.

Recommendations⁴

Below, in Section 3.5.2, Recommendation 8 calls for JHPIEGO to continue its support to BEMFAM. The following recommendations (numbers 1 through 5) are pertinent only if the BEMFAM effort continues.

- (1) **JHPIEGO should monitor BEMFAM training and service provision processes more closely in order to identify areas for technical support. Greater medical supervision should be provided by BEMFAM to the project.**
- (2) **BEMFAM supervisors need specific training in supervision of clinical services in order to become familiar with the programmatic areas in a clinical program that they should oversee. Medical leadership at the state level also should be strengthened to enable it to provide necessary technical backup to the supervisors.**
- (3) **In the BEMFAM project, reproductive risk should be emphasized as an important concept and tool but not as the main focus of the project (unless MOH policy changes permitting referral of only at-risk women to the physician). CHW activities should be redirected from emphasis on reproductive risk classification to IEC.**
- (4) **JHPIEGO and other A.I.D. CAs need to address the lack of information and the misinformation surrounding the IUD, particularly in Brazil's Northeast region.**
- (5) **JHPIEGO-supported projects must seek ways to assure sufficient IUD cases to achieve training competency (see Recommendation 17 regarding use of anatomical models to supplement training on actual IUD cases).**

3.2 CPAIMEC: Completed JHPIEGO Model — In-Service Training for Specialist Teams, Primarily to Provide VSC

3.2.1 Project Evolution

JHPIEGO has achieved its greatest impact through the CPAIMEC project, which, together with the U.S.-based JHPIEGO training, served to expand family planning services,

⁴Recommendations in boldface type are the principal recommendations in this report.

particularly in the private sector. CPAIMC trainees came from all types of institutions: private non-profit institutions; private for-profit institutions with government contracts to serve the public; and public sector institutions. Now phased out, the project reached its zenith during the early 1980s, when Brazil's leading ob/gyns seized the opportunity to train in laparoscopy and receive laparoscopic equipment donated by JHPIEGO. As a result, many became interested in family planning and started large service delivery programs at the institutions with which they worked — mostly public sector or private non-profit institutions. Some (particularly university professors and physicians in public hospitals) had difficulty in starting such programs. Whereas those at public hospitals tended mainly to use their new laparoscopes at their own institutions (and in their private practices) for sterilization, many of the professors established their own private non-profit organizations. Believing that they needed an organization to represent their interests, they moved, at a JHPIEGO-sponsored meeting, to create an organization to represent their interests. The institutional network that resulted led to the creation of ABEPF — the Brazilian Association of Family Planning Organizations — with 130 affiliates, mostly private non-profit institutions. These included more than one dozen regional in-service training centers that were established around the country as part of the JHPIEGO project. During the mid-80s, these were the sites for practice training, particularly for laparoscopy, after the CPAIMC trainees had completed their didactic training at CPAIMC. Most of the JHPIEGO training centers became the recipients of assistance from Family Planning International Assistance (FPIA), Association for Voluntary Surgical Contraception (AVSC), and Development Associates, Inc. (DA).

CPAIMC itself also became an impressive operation. Based at St. Francis of Assisi Hospital in Rio de Janeiro, it had in-patient clinical facilities which also served as clinical training sites for ob/gyns from throughout the country. It also created over 40 primary health care (PHC) posts in low-income sections of Rio.

In summary, the JHPIEGO project 1) made interval VSC services available for the first time in Brazil in both *public and private* institutions (the latter were mostly non-profit) and presumably reduced the cesarean rate at sites where serious programs were implemented (although there are no data to support this); 2) like BEMFAM, extended services to poorer areas of the country; 3) like BEMFAM, created clinical sites that could be used as training laboratories for other JHPIEGO trainees; and 4) for the first time, introduced the concept that women should have access to all methods in institutional settings (prior to this, the full range of methods was available only from a small number of physicians in private practice). With regard to this latter contribution, some trainees failed to provide accessible clinical family planning services in conjunction with VSC, perhaps as a result of the over-emphasis of laparoscopy in their training: The methods were/are available on-site but not organized so that women know they are available.

The phase-out of the CPAIMC training stemmed from two factors, one local and the other U.S.-based. Locally, the switch in 1984 from laparoscopy to minilaparotomy was greeted negatively by doctors, who liked the laparoscope and the wider range of reproductive health diagnostic procedures it made possible. As a result of this change, demand for training fell and regional training center activities had to be discontinued. Later, primarily in the interest of sustainability and in response to some management problems, A.I.D. funds for CPAIMC began to be reduced. As a result, CPAIMC had to cut back its training and service programs. In 1989, JHPIEGO terminated support to CPAIMC. Thereafter, CPAIMC closed all of its community PHC posts, ceased all training, and now operates only a central clinic.

Because of its initial emphasis on laparoscopy, JHPIEGO's early training work in Brazil has negatively associated JHPIEGO, A.I.D., and NGOs, particularly CPAIMC, with

sterilization. The effect has been to hinder effective collaboration with the government. Specifically, private sector family planning leaders believed that training could be sustained after A.I.D. support was withdrawn by marketing training to the public sector, other private sector institutions, and private clinicians. CPAIMC's efforts to offset its losses in A.I.D. funds have been unsuccessful, however. Demand for family planning training from the public sector, the most likely source of funds, has been small. The other possible purchasers, private institutions and universities — though less concerned with the issue of sterilization — have not had the funds available to purchase in-service training.

3.2.2 Impact and Institutionalization

Despite the phase-out of CPAIMC's training efforts, CPAIMC has had a significant long-term impact in Brazil. Many of the young physicians trained at CPAIMC and the regional training centers in the early 1980s are now full university professors, senior state-level public health officials, and national and state leaders in professional associations for obstetrics/gynecology and human reproduction. Given their leadership positions and experience, these same individuals are called upon, particularly by state and federal governments, to shape family planning policy in Brazil (e.g., recently, they helped pave the way for inclusion of Norplant, injectables, and VSC [the latter in "special circumstances"] as contraceptive methods to be provided by the public sector).

3.3 Pre-Service Training: Completed JHPIEGO Model — Incorporation of Family Planning into Medical School Curricula

The three pre-service training institutions that JHPIEGO supported in the early 1980s have all incorporated family planning into their curricula. In most cases, family planning is presented theoretically during the students' coursework on gynecology. Practice training is only sporadically available. JHPIEGO's efforts in pre-service training were followed by programs funded by Pathfinder. Pathfinder is also assisting medical schools in the Northeast to establish family planning service programs to be used for training of both students and physicians at large in family planning. Despite these combined efforts, the schools affected represent only a tiny minority of Brazil's medical training establishments. Most of Brazil's 71 medical schools and 89 nursing schools do not include reproductive health in the curricula.

Pathfinder has also assisted FEBRASGO (Federacao Brasileira de Sociedades de Ginecologia e Obstetricia), the national federation of ob/gyns, in its efforts to develop standard family planning curricula for medical schools as well as training materials. It has had little success in this area, however. Currently, whether reproductive health is taught in these schools depends on departmental policy and, particularly, the specific interests of the professors involved.

3.4 JHPIEGO Training Model for Brazil under Negotiation: Training of Trainers for Implementation of Public Sector Family Planning Services

The in-service training project for the public sector that JHPIEGO is currently negotiating, through which training of trainers (TOT) will be conducted at SAMEAC in Fortaleza and later at the Edgard Santos Hospital at the Federal University of Bahia in Salvador, represents a very significant development. Not only does it signal one of the first times that an A.I.D. CA has

been sought by the MOH to assist PAISM; it should also make a number of important contributions to the public sector program in Brazil.

Although PAISM has been providing family planning training for nearly five years, this effort has not led to implementation of public sector family planning services. JHPIEGO has recently convinced the government to downsize the initial training plan, which would have involved initiating training in 27 locations, to a more manageable effort involving only a small number of initial sites. This new approach should go a long way in rectifying methodological and content problems that have plagued previous training for PAISM. Because inadequate training has been the main factor in slowing program implementation, JHPIEGO's involvement should contribute to hastening provision of family planning services in public sector facilities. If successful, the initial approach will undoubtedly be replicated in all PAISM state training centers.

The only limitation to the proposed model for the public sector is that, for political reasons, it does not include training in VSC. This is a serious drawback, since the majority of sterilizations at the time of cesarean section occur in public and private for-profit hospitals and thus one of Brazil's greatest training needs is in both post-partum and interval minilaparotomy in these facilities. JHPIEGO needs to be attentive to the first politically feasible opportunity that arises to include VSC in the training curriculum.

3.5 Recommended JHPIEGO Strategy for Brazil

3.5.1 Conclusions

JHPIEGO's training of over 5,000 physicians, medical and nursing students, and community health workers over a 12-year period stands as a major accomplishment. In relation to the need in the country, however, the impact must be viewed as less than comprehensive. JHPIEGO has trained probably upwards of 2,000 physicians (primarily ob/gyns); another unknown, but certainly smaller, number of physicians have been trained by the government, other donor agencies, and by universities providing pre-service training. With some 10,000 ob/gyns in Brazil, clearly additional training could fruitfully be offered to make clinical family planning services more widely available.

Since the need for training in all sectors remains great, at this point it is difficult to single out just one type of training or a specific health sector that warrants exclusive JHPIEGO assistance. The public sector needs in-service training urgently to meet current demand for services. Universities need to be providing pre-service training in preparation for future service demands. The private non-profit sector continues to play an important role in introducing new family planning methodology and technology, and can be an important JHPIEGO ally in this process. JHPIEGO could make useful contributions in coming years in all these areas. In addition, JHPIEGO needs to diversify its target audience to include non-clinical personnel who are important elements of the family planning team in Brazil.

In-Service vs. Pre-Service Training

JHPIEGO has placed a greater emphasis on in-service than on pre-service projects, and it has succeeded to some degree in extending in-service training in the private sector through regional training centers established by JHPIEGO and supported by other donors. Such training has been drastically curtailed, however, as external funding has been reduced.

With regard to the pre-service projects, a few schools now have a curriculum that includes reproductive health; still, the proportion of all schools with family planning in their curricula is very small and there is no nationally accepted curriculum that would allow replication of a family planning component throughout the country. Currently, very few health personnel begin their practices with any knowledge of family planning. Given the size of Brazil, it would clearly be impossible for JHPIEGO to attempt to initiate curriculum change piecemeal, medical school by medical school. Rather, a more global approach is needed, focusing on formation and change of government educational policies to support inclusion of reproductive health in the curricula of all the country's medical and nursing schools.

Role of the Private Non-Profit Sector

JHPIEGO's assistance to the private non-profit sector has been well placed; this sector has had, and will continue to have, an important role in institutionalizing the provision of reproductive health services in Brazil. Not only has it increased service availability among public and private sector providers (CPAIME training for doctors made VSC services more accessible throughout Brazil, particularly at private voluntary organizations [PVO]); it has also increased services in the public sector (BEMFAM training has integrated the BEMFAM community program in the Northeast within municipal health services). Moreover, it has made important contributions in meeting the needs of poorer sectors of the country, in providing a full range of methods in institutional settings, and in integrating family planning into MCH services.

Involvement with the Public Sector

JHPIEGO's assistance to the private non-profit sector has been useful, but it has not made personnel trained in family planning universally available. Rather, it has provided services in some parts of the impoverished Northeast and to clients of institutions whose ob/gyns were trained either through CPAIME or at the three pre-service university training centers. The PAISM project thus offers an important opportunity to make family planning far more widely available.

3.5.2 Recommendations

JHPIEGO's plan to become involved with PAISM represents a timely and relevant move, but, in terms of the problems and opportunities discussed above, does not go far enough. Rather, JHPIEGO should develop a broad new strategy that would also continue the good work with BEMFAM and reactivate activities with pre-service training. Specifically, over the next 10 years, JHPIEGO's reproductive health training and education activities should pursue a strategy including the following four activities, with priority in the order they are listed:

- **Institutionalization of Pre-Service Training in Schools of Medicine, Nursing, and Social Work**
- (6) **JHPIEGO's early work in pre-service training should be re-activated and coordinated with other CAs, particularly with Pathfinder. Priority attention should be placed upon promotion of activities that will contribute to policy formation and change in order that reproductive health be officially included in the curricula of schools of medicine, nursing, and social work. The next priority should be training of trainers in reproductive health and appropriate educational technology.**

- **Implementation of Public Sector Family Planning Services, via Training of Trainers**
- (7) **JHPIEGO should continue its efforts to initiate training assistance for the public sector women's health care program, PAISM. Support needs to be provided for training of trainers at MOH-designated training centers and other state or municipal training programs designed to implement PAISM. JHPIEGO assistance should be coordinated with other international donors that are now considering focusing their support on specific states and/or municipalities to assure PAISM implementation in these areas.**
- **Strengthening the Private Non-Profit Sector, via Training of Trainers and In-Service Training**
- (8) **JHPIEGO should continue to support private sector family planning training. Prime emphasis should go to continuing support for integration of the BEMFAM community program because of its significance in expanding public sector family planning services, particularly in the Northeast. JHPIEGO should also expand its activities to the five remaining Northeast states where it has not previously provided training support.**
- (9) **JHPIEGO should look to the private non-profit sector as an important partner in expanding reproductive health services in Brazil, and as such, dedicate considerable effort to strengthening private sector institutional relationships. Thus, JHPIEGO should support training of trainers and, when appropriate, in-service training at private institutions that present opportunities to transfer training and service technology to the public sector and other private sector institutions.**

4. Training Issues

Previous Page Blank

-25-

4. Training Issues

4.1 JHPIEGO's Technical Performance

4.1.1 Selection Issues

On the whole, JHPIEGO-supported training in Brazil has succeeded in reaching future providers of family planning services. For example, in the case of BEMFAM, the CHWs trained under the project work in the BEMFAM community program at the time they are selected for training and they return to the program following training. The physicians selected for BEMFAM training are well known and recommended by BEMFAM's field staff. Likewise, when the CPAIMC project was at its height, its targeted physicians, almost without exception, utilized their training, providing family planning in many locations nationwide.

It is not always easy for local institutions such as CPAIMC and BEMFAM to select the most suitable candidates, however. JHPIEGO application forms are lengthy, are frequently completed incorrectly, and do not provide the information necessary to evaluate candidate eligibility for training. Another issue, less under JHPIEGO's control, is the tendency, seen in the BEMFAM project, of the government to transfer trained family planning workers into other jobs. In order to assure maximum training utilization as JHPIEGO initiates support for public sector training, the trainee selection process requires re-formulation.

Recommendations

- (10) JHPIEGO's application forms need to be reviewed and modified as a means of improving the selection process. Field visits could be used to assist in trainee selection.
- (11) As JHPIEGO plans training projects with the public sector, particular attention should be focused on trainee selection to increase the probability that trainees will work in family planning.

4.1.2 Technical Support in the Field

Most likely as a result of an insufficient number of staff at headquarters, JHPIEGO has provided inadequate technical support to its projects in the field. The lack has been most notable in the areas of curriculum development, teaching skills, and clinical skills.

In the case of CPAIMC, for example, the JHPIEGO project was the first teaching experience for most of the instructors. In the case of BEMFAM, although the organization has significant training experience, the JHPIEGO project was its first experience with clinical training. Both BEMFAM and CPAIMC training staff could have benefited from JHPIEGO-assisted training of trainers.

JHPIEGO has also not always provided adequate clinical support to its training projects in Brazil, particularly in problem areas such as infection prevention. A number of years ago, a problem arose with regard to disinfection and sterilization of laparoscopes. Many of the physicians

trained at CPAIMC began to use ultraviolet light for sterilization of the laparoscope. This would have been a good opportunity for JHPIEGO to take an active role in providing technical support to teach proper alternative practices. In the end, AVSC took the lead and worked through ABEPF to inform and advise institutions about prevention of infection via the laparoscope.

JHPIEGO has not always been familiar with the technical skills and practices of the instructors for the training projects it supports. The considerable training in non-recommended techniques of anesthesia for VSC could have been avoided had JHPIEGO been familiar with the anesthesia practices of the BEMFAM training center in Pernambuco (see Section 3.1.3).

The high level of technical skills of local project personnel has prevented the lack of technical backup from having serious medical consequences. Furthermore, JHPIEGO has recognized the need to address its deficiencies in this area and is currently planning to use local consultants to advise the JHPIEGO-supported project in these areas. A number of consultants have been identified, most of whom are former JHPIEGO trainees and who represent some of the most highly skilled family planning personnel in Brazil.

Recommendation

- (12) **During project implementation, JHPIEGO should provide stronger technical support, particularly in the areas of curriculum development, teaching skills, and clinical skills (specifically infection prevention and anesthesia for VSC).**

4.1.3 Field Follow-Up

Other donor agencies, particularly AVSC, have supported post-training field visits in Brazil to assist trainees with service implementation. During these site visits, which have been very successful, additional training is provided, if needed; adherence to quality standards of care is observed and orientation provided; needs for equipment, supplies (particularly contraceptives), and other materials are identified and resolved; and the need to train other family planning personnel is assessed and arranged. In the past, as part of the JHPIEGO project, CPAIMC conducted post-training field visits, but the visits were conducted by surgeons and focused on the trainees' performing additional laparoscopies at his/her home institution as the final stage of training, with very little emphasis on the institutional setting and its readiness or ability to initiate full (clinical and surgical) service provision.

Recommendation

- (13) **Post-training field visits should be made to help ensure that training is utilized in service implementation and to provide such support as equipment and supplies, scientific publications, and training for other staff members (i.e., other team members such as nurses, auxiliaries, and even other physicians). Post-training support in the public sector should be coordinated by state secretariats of health who are primarily concerned that personnel trained in the state training centers actually utilize their training.**

4.1.4 Monitoring Support

JHPIEGO monitors the BEMFAM project through trainee evaluations, site visits, project progress reports, and when available, results from Annual Participant Surveys (APS). It does not, however, make an adequate effort to assess training and service provision processes in order to identify areas for technical support. With the exception of site visits, all of JHPIEGO's monitoring procedures are conducted in Baltimore, far from the project. Site visits are the only opportunity JHPIEGO staff has to observe actual project activities. It appears, however, that JHPIEGO site visits have concentrated more on project planning, management, administration, and evaluation than on direct observation of actual training and service provision.

Recommendation

- (14) **In order to identify areas for technical support, JHPIEGO should attempt to improve its monitoring process by dedicating greater effort to assessment of the training and service provision processes.**

4.1.5 Educational Materials

In general, the educational materials that JHPIEGO provides are useful as reference materials but not appropriate as instructional materials. Brazilian trainers are not fully familiar with the materials' content and do not use the materials during the training courses. For training, both trainers and participants prefer training manuals that present the course material, such as the series of modules that BEMFAM has prepared for CHW training.

Of the materials distributed by JHPIEGO, *Population Reports* is the best received. It is more useful, however, as reference material than as course material. It should also be noted that the lag-time between the English- and Portuguese-language editions is often great, resulting in dissemination of slightly outdated information.

Educational materials are not always pertinent to the training content. During the final years of the CPAIMC training project, which emphasized IUD and minilaparotomy training, each physician received a packet of materials that included a manual (in Spanish) on the treatment of diarrhea. Even though the diarrhea manual may be interesting and useful, the trainees' ability to absorb all of the materials may have been reduced because of the volume of materials distributed.

Many of the educational materials provided by JHPIEGO are in Spanish, which is understood by the majority of physicians and nurses. Spanish is, however, not the language of Brazil and therefore creates a barrier to full utilization of the material. Also, for BEMFAM training courses, JHPIEGO has been distributing Spanish-language copies of two booklets that are available in Portuguese.

For the future, JHPIEGO is planning to provide documentation on service standards as key course materials. The service standards would best be presented through a training manual specifically designed to present course information. In the past, JHPIEGO used case studies for REHEP training, which were well received. They were an asset in didactic training as they associated use of the standards with real-life situations.

JHPIEGO provides institutions with basic equipment, such as IUD kits, but does not supply materials for family planning IEC activities. By implication, this downplays the significance of IEC activities in service provision. Likewise, there are inadequate supplies of professionally prepared but simple teaching aids, such as slides, videos, flip charts, and contraceptive displays.

Teaching aids, particularly the pelvic models for training in IUD insertion, are not fully utilized; this is because, in most cases, JHPIEGO sent the models to the training centers but did not train the instructors how to use them. The models are familiar to most trainers but are not found in all of the clinics. In addition, although JHPIEGO supplies models for IUD insertion, it provides none for training in diaphragm fitting (a simple, preferably cross-sectional, pelvic model).

Recommendations

- (15) **JHPIEGO should provide educational materials in Portuguese covering service standards, training (with need-to-know information), and case studies.**
- (16) **In addition to equipment (such as IUD and minilap kits), all trainees should receive some type of IEC material — preferably a flip chart.**
- (17) **All trainers should receive instruction in the use of anatomical models for training. JHPIEGO should also supply all training centers with models not only for IUD insertion but also for diaphragm fitting.**

4.1.6 Staffing Constraints

JHPIEGO's record to date on technical back-up raises the question of future support, given the volume of work to be developed in Brazil in the public sector in the coming years. The new project will require a more consistent approach to strategy formulation and planning, and the implementing agencies will need strong technical support. The dimensions of the job may be too large to be met through technical assistance provided by JHPIEGO staff from Baltimore. Many of the shortcomings identified in the planning and implementation of projects could, however, most likely be overcome by having a local representative.

Recommendation

- (18) **In order to strengthen strategy formulation, project planning and implementation, and programming of technical support for Brazil, JHPIEGO should contract an in-country representative/project coordinator.**

4.2 A Training Strategy for Brazil

4.2.1 Clinical Staff

Currently, reproductive health is not offered widely in Brazil's medical schools. This lack of emphasis reflects the viewpoint of the majority of educators in decision-making positions in Brazil's medical and nursing schools — older, traditional educators who are not sensitized to the importance of teaching reproductive health. This should change over time, however, as younger

professors who consider reproductive health to be an important part of medical and nursing education gradually assume significant leadership roles in schools of medicine and nursing.

The public sector training project under negotiation with the MOH contemplates that JHPIEGO will provide significant curriculum development support. This is much needed, and JHPIEGO has made some recent advances in its training approach which will most likely be appropriate for the Brazil setting. For one, it has recently developed a new approach to clinical skills training, based on training-to-service standards. This approach will provide the trainees with exactly the information they need to know to be able to provide services according to PAISM/MOH standards for family planning services. JHPIEGO's use of anatomical models also deserves much wider application.

Recommendation

- (19) **Training of trainers in reproductive health, whether for pre- or in-service training, should provide trainers with clinical skills and with the teaching skills and educational technology necessary to achieve training-to-service standards. The importance of providing training in reproductive health within the context of women's health care should be stressed. Humanistic teaching techniques (i.e., the use of anatomic models) and the team approach should also be included in training.**

Physician Training

At this point in Brazil, the educational and training needs of physicians with regard to reproductive health differ very little from those of medical students. Most practicing physicians have had very little training in reproductive health and have been taught nothing about clinical methods. The vast majority of ob/gyns also do not know how to manage oral contraceptive side effects or fit a diaphragm. Because IUD and Norplant prevalence is very low in Brazil, very few ob/gyns are familiar with these methods. Thus, this group requires comprehensive training with emphasis on all contraceptive methods.

The only physicians who have had basic family planning training are the small core who have been trained by JHPIEGO, Pathfinder, or AVSC, or through some university pre-service training programs. This group requires additional specialized training not included in basic training.

Recommendations for Physician Pre- and In-Service Training

- (20) **All JHPIEGO-supported physician training, both pre- or in-service, should include provision of contraceptive services within the context of women's health care. All contraceptive methods should be emphasized equally. Training in minilaparotomy should be resumed and provided along with training in other methods. Training in laparoscopy, due to its dependence on expensive, imported supplies, should be conducted only in special circumstances (e.g., the institution has the equipment but no one is trained to use it).**

In addition to the standard curriculum, training for Brazilian physicians should emphasize contraceptive counseling, quality of care, prevention of infection, and the human element in providing health care. Genital tract infection identification and management will require considerable training effort.

- (21) **Separate specialized training should be made available to providers who have already received basic training in reproductive health but whose training did not include specific methods or content areas. Their training should include family planning (including VSC) counseling, management of genital tract infections, prevention of infection, quality care, Norplant, immediate post-partum IUD insertion, post-partum minilaparotomy, and vasectomy.**
- (22) **JHPIEGO-supported public sector training should stress maternity-based family planning (post-partum and interval management of all contraceptive methods, including VSC when politically feasible) integrated with other PHC actions.**
- (23) **For practice training, an institutional approach should be taken that would evaluate training needs based on the staffing patterns of the trainees' institutions and that would designate clinical and/or surgical training accordingly.**

Nurse Training

In Brazil, physicians greatly outnumber nurses, who are in very short supply. Consequently, nurses are most frequently responsible for health care administration and/or supervision as opposed to patient care. Given this situation, it is unrealistic to assume that nurses will be the primary providers of family planning care, although they will have a role in supervising technical and auxiliary nurses who are involved in client care.

At this point, almost no Brazilian nursing schools offer training in family planning and thus, like physicians, nurses and nursing students have much the same educational and training needs.

Recommendations for Nurse Training

- (24) **Both pre- and in-service training for nurses should include both service provision and family planning service management. At the current stage of family planning services development in Brazil, nurse training in family planning clinic management should emphasize service implementation — that is, how to initiate family planning service provision in a given institution.**
- (25) **Didactic training for nurses and nursing students should emphasize, in addition to clinical skills, family planning information and counseling, quality of care, and the human element in provision of care.**

4.2.2 Non-Clinical Personnel: Team Approach

Family planning services are often implemented in Brazil at the initiative of non-medical staff (social workers, psychologists, and social scientists) who may be the first to recognize a client's need for family planning services. During their university training, these categories of personnel receive no instruction in reproductive health. Rather, they receive training in-service, after they are selected as part of an institutional team that will initiate service provision.

The team training focuses on clinical skills as well as on the basic administrative skills needed to initiate services. Although in many cases individual members of the health team are not trained together, providers are trained in clinical skills based on a team approach. In addition,

whenever feasible, providers are not placed for training in strict provider categories. Nurse training courses may include different levels of nurses, since not all institutions have nurses. Courses for CHWs may include auxiliary nurses and sociologists, depending on the institutional availability of human resources. In addition to physicians and nursing personnel, social workers, psychologists, social scientists, and administrators are considered important team members who require training.

Insofar as possible, JHPIEGO has sought to follow the training strategies of the local institutions with which it is involved. JHPIEGO's mandate limiting its work to physicians, nurses, and midwives, however, could preclude its training of the non-clinical personnel. This could present a problem with respect to the PAISM effort, since successful implementation will require a team approach.

Recommendations

- (26) **JHPIEGO should take an institutional approach to training — that is, training trainers to train teams of physicians, nursing personnel, CHWs, social workers, and other professionals to implement services. This might require a broadening of JHPIEGO's mandate.**
- (27) **Training for the social workers, psychologists, and social scientists who are involved in identifying potential family planning clients should be both didactic and practical. Considerable emphasis should be placed on implementation of family planning services, service standards, the various methodologies for service delivery (for example, maternity-based, employment-based, community-based), information and counseling, quality of care, and integration of family planning with other health and social services. This information should be provided to social workers during their pre- and in-service training. For other similar professionals, it should be provided in-service.**

4.3 Training Location

In the past, practice training has seldom been a problem for JHPIEGO since most of the training it has supported has been conducted by NGOs whose facilities reflect real-life situations. The main exception has been with IUD training, for which sufficient caseloads have rarely been available (see Section 3.1.3).

The PAISM program, however, primarily uses university clinics for its clinical training. This could present problems. Brazilian university family planning clinics have too few cases to afford the volume of clients necessary for training. Moreover, they tend to be very unlike other health care facilities since their human and material resources tend to be richer.

Recommendation

- (28) **JHPIEGO must make sure that training centers offer ample opportunity for practice training (e.g., as in municipal and state health centers and maternity hospitals and NGOs). This will be particularly important in the PAISM effort. With respect to pre-service training for medical and nursing students, JHPIEGO should support such training only at schools that can offer practice training in real-life situations.**

5. Management Issues

Previous Page Blank

-35-

5. Management Issues

5.1 Project Staff

JHPIEGO has a well-qualified and highly trained public health staff. JHPIEGO personnel, particularly its regional staff for Latin America and the Caribbean (LAC), possess the health and cultural skills necessary for the work they perform. On the other hand, JHPIEGO's regional staff for Latin America and the Caribbean lack appropriate expertise in education and training. Regional staff is also small in relation to the needs for technical assistance in Brazil.

Recommendation

- (29) **JHPIEGO headquarters staff needs to be enlarged, and greater staff technical support should be provided in education and training. The level of reinforcement will depend on whether a local representative is hired (see Recommendation 18) and the degree to which local consultants are used.**

5.2 Project Planning

JHPIEGO's planning for activities in Brazil has been deficient, both with respect to strategic planning for the overall program and with respect to details for project implementation. It must be recognized, however, that A.I.D.'s emphasis on sustainability in preparation for eventual funding withdrawal has greatly affected JHPIEGO's planning process in recent years. JHPIEGO, as well as other CAs, has had to preoccupy itself more with closing out projects than on developing new ones. At least two new JHPIEGO projects have been prepared but not approved by A.I.D./Brazil.

With regard to specific project planning, although JHPIEGO project proposals are well prepared, staff have not always assessed institutional capacity to execute project activities (e.g., the lack of opportunity for BEMFAM physicians to practice IUD insertions reflected a failure in this regard). Likewise, there has been on occasion insufficient feedback into the planning process (e.g., when major changes with respect to reproductive risk occurred in BEMFAM's contraceptive service delivery model, the project was not replanned to make the appropriate accommodation [see Section 3.1.1]).

JHPIEGO's inadequate programming of technical support may also reflect a weakness in the planning process. All the institutions that have received assistance from JHPIEGO required technical support, but JHPIEGO appears not to have assessed these institutional needs during the planning phase.

Most of the on-going JHPIEGO projects were originally planned before A.I.D. funding reductions in Brazil were a major concern, and thus sustainability was not emphasized in the planning process (with the exception of laparoscopic equipment maintenance, which was designed to allow for the phase-out of JHPIEGO support). In the upcoming public sector in-service training project, however, sustainability is being incorporated into the project design.

In addition to including sustainability at the design stage, JHPIEGO is improving its planning process in other ways. For example, the transition to public sector training is the result of improved strategic planning. The hiring of a local representative should greatly improve both strategic and specific project planning.

Recommendation

- (30) **Project planning must become a more dynamic process, based on up-to-date country-specific strategies that are coordinated with overall A.I.D. strategies. Institutional capacity needs to be carefully assessed during the project planning process in order to program technical support. Projects should be replanned as strategies or policies change.**

5.3 Administrative Support

JHPIEGO provides solid management and administrative support to its projects. Project proposals are written clearly, and staff from all organizations interviewed commended JHPIEGO on the large effort expended by JHPIEGO staff to monitor projects.

With regard to project financial management, funds arrive on time and all arrangements work smoothly. JHPIEGO's method of reimbursement on a tuition basis (compared to cost reimbursement) is well received by JHPIEGO implementing agencies. Due to inflation, however, there is a need to monitor tuition calculations closely. Since tuition is calculated on the basis of costs in local currency converted to U.S. dollars at the time the project is planned, tuition reimbursements may not cover actual costs at the time of training.

5.4 Evaluation

5.4.1 Trainee Evaluation

All JHPIEGO-assisted projects use the same basic instruments to evaluate trainees: Pre- and post-tests of participants' knowledge are administered and competency-based assessments are made of participants' clinical skills. The BEMFAM project uses several additional approaches: The SAMEAC training of BEMFAM physicians includes trainee self-evaluations at the completion of the course; CHWs complete a post-test of participant knowledge to measure retention of information three months after training; and physician supervisory visits are also conducted, though not in a systematic fashion that could be used for evaluation purposes.

5.4.2 Training Evaluation

All JHPIEGO-supported training activities have a strong training evaluation component. The tools used vary among institutions and include daily written course evaluations, general course evaluations, and individual instructor evaluations completed at the end of the course. Trainers utilize these tools well for training improvement.

In addition, the BEMFAM training projects have built-in evaluation workshops, which are used to modify future training. Trainers are very satisfied with the results of these workshops.

5.4.3 Routine Impact Evaluation

JHPIEGO's weakest evaluation area is impact evaluation. The primary tool is the Annual Participant Survey (APS). Its data collection instrument is seen as culturally inappropriate. In addition, its validity and reliability are also highly questionable, since it depends heavily on the trainee's statistical records of his/her individual performance. Clinicians in Brazil do not keep their own records of services performed, and institutional information systems are weak, making it very difficult to obtain service delivery data from training participants. Moreover, due to the difficulties in collecting the data requested by the instrument, the survey is seen as a burden to trainees and to the training centers that must execute it.

As an evaluation tool, the APS has failed to provide timely and relevant feedback information to the training centers. The delay between collection of the data and feedback of information to the training centers often exceeds one year. The instrument has also not been revised since it was implemented in the early 1980s. The Portuguese version of the instrument reflects JHPIEGO's initial training projects with CPAIMC, with emphasis on team training (surgeon/anesthesiologist/nurse) for laparoscopy. The instrument should have been changed long ago to reflect JHPIEGO's current projects in Brazil, which have emphasized reproductive risk, IUD insertion, and minilaparotomy.

5.4.4 Special Impact Evaluations

JHPIEGO has conducted two impact evaluations in Brazil. The BEMFAM reproductive risk project underwent an initial evaluation in the mid-1980s to compare CHWs' classifications of reproductive risk to those of physicians. The objective of the evaluation was to identify the at-risk clients who needed to be referred to the physician and those who could be cared for by CHWs. Due to the evaluation design, sound conclusions could not be drawn. Data processing problems were also encountered by BEMFAM, which delayed the results of the study. By the time the results were ready, BEMFAM had already instituted a policy of referring all clients to physicians as mandated by MOH norms. The evaluation did, however, provide data on service users.

Building upon experience with the first impact evaluation, JHPIEGO is currently supporting a special assessment of the BEMFAM reproductive risk approach. Technical assistance is being provided by Family Health International (FHI). This is a well-designed evaluation and should serve to analyze the long-term impact, quality, and performance of the project. Specifically, it is seeking to establish the usefulness of requiring women to visit a physician before beginning family planning services (e.g., how many actually comply? are methods used appropriate for level of risk?) and to learn whether physicians use the training they have received. The study is expected to demonstrate that CHWs assess reproductive risk as well as physicians. The findings will allow BEMFAM to fine-tune its training and service models. In addition, the results could be used as evidence to change the policy that now requires that most contraceptive care be provided by physicians.

An important aspect of special impact evaluations is the high degree of involvement by local staff. BEMFAM staff strongly identify with the on-going evaluation, in particular in

comparison to the APS, and look forward to obtaining and utilizing the results to improve program performance.

5.4.5 Other Suggested Areas for Evaluation and Information Dissemination

The 1991 Demographic and Health Surveys (DHS) in the Northeast (or other survey data) offer rich opportunities to gain baseline data from which training needs can be identified and training impact evaluated. As JHPIEGO begins to support the development of state training centers for PAISM, JHPIEGO must work together with other CAs and international agencies to encourage the MOH to utilize these data. Particular attention needs to be paid to evaluation of changes in method mix, source of contraceptive supply, and timing of sterilizations (whether post-partum or interval) at state and, sample size permitting, municipal levels. Sentinel hospitals should be identified for monitoring of cesarean section rates and, as other PAISM components are implemented, maternal mortality.

An evaluation needs to be performed of JHPIEGO's training activities in the private sector. The purpose of such an evaluation would be to conduct an in-depth training needs assessment of this group and formulate specific strategies for JHPIEGO assistance.

Since many Brazilian ob/gyns rely on cervical cytology smears to identify genital tract infections, and therefore require a recent Pap smear for IUD insertion, JHPIEGO needs to disseminate alternative means for IUD management and for prevention of IUD-associated infection. As most public health facilities in Brazil do not have adequate cervical cytology support, requiring a Pap smear will greatly limit IUD accessibility.

Many surgeons and anesthesiologists dislike utilization of local anesthesia with sedation for VSC. JHPIEGO needs to conduct an in-depth analysis of anesthesia issues in order to address them more directly in training programs.

Health providers in Brazil, particularly in the Northeast, are often misinformed about the most effective low-prevalence methods, such as the IUD and Norplant. Large-scale training programs, such as that under negotiation with the MOH for PAISM, must include a considerable information component for health providers in order to improve method acceptability.

Delegation of functions to nursing personnel and CHWs is another area in which JHPIEGO should provide evaluation support. The BEMFAM evaluation is a first step in this process. Nevertheless, MOH norms currently centralize almost all family planning client care with physicians. JHPIEGO needs to assist the public sector in evaluating those functions that can be safely and effectively delegated to nursing personnel and CHWs under medical supervision.

Recommendations

- (31) **Due to the impossibility of collecting quantitative provider data, the APS should be discontinued or considerably revised to allow for collection of qualitative data from a representative sample of trainees or institutions.**
- (32) **Special impact evaluation should be the methodology of choice of all JHPIEGO-supported training projects in Brazil and should focus on service quality as opposed to quantity.**

- (33) The results of the BEMFAM impact evaluation must be widely disseminated in Brazil, particularly in the public sector.

5.5 Collaboration with Other Institutions

5.5.1 Relationship with In-Country Organizations and Groups

Government and Professional Associations

JHPIEGO's relationship with the MOH/CORSAMI is only fair. The MOH questions the true motives of A.I.D. support for both JHPIEGO and other CAs. In the case of JHPIEGO, this apprehension is particularly acute due to JHPIEGO's history of financial support to VSC training activities in Brazil. Nevertheless, the JHPIEGO staff has done an excellent job of introducing the institution to the MOH and identifying ways in which JHPIEGO can support PAISM training needs.

JHPIEGO has only recently initiated contacts with other divisions within the MOH. It is thus premature to assess JHPIEGO's relationships with these groups. Nevertheless, JHPIEGO is doing well in expanding its contacts within the MOH in order to assure full cooperation with the PAISM training centers for project implementation.

Among professional medical bodies, such as FEBRASGO, SBRH (Sociedade Brasileira de Reproducao Humana), and the state-level ob/gyn societies, JHPIEGO is a well-known and well-respected organization. Many of the members of the executive boards of these organizations are former JHPIEGO trainees. Establishing relationships with these bodies could well be advantageous for JHPIEGO, particularly now as they could be influential allies who could be mobilized for policy change.

JHPIEGO has not initiated contacts with professional nursing associations in Brazil, which are important groups that also need to be mobilized to support reproductive health training and services.

JHPIEGO does not have a relationship with the MOEd and has not maintained its relationships of the early 1980s with universities. Such ties will become essential in the future, if JHPIEGO begins to give priority to training of trainers for pre-service education for physicians, nurses, social workers, and primary and secondary school teachers.

Relationships with Former Trainees

JHPIEGO has created a strong group of allies who take pride in being "JHPIEGO graduates," many of whom are involved in various medical associations and with ABEPF. JHPIEGO has not, however, made enough effort to invest in relationships that would capitalize on these old ties. ABEPF was created as a direct result of JHPIEGO training in Brazil, yet JHPIEGO has not maintained a working relationship with the organization that represents Brazil's family planning leaders. For example, it missed several important opportunities for collaboration with ABEPF, such as development of family planning service delivery norms (which could be used as training standards), training manuals, and infection prevention routines for VSC. These activities were prepared in cooperation with other CAs and could be of benefit to many JHPIEGO trainees in Brazil.

Recommendations

- (34) **JHPIEGO should develop ties with Brazilian physician and nursing professional associations, the MOEd, and schools of medicine, nursing, and social work.**
- (35) **JHPIEGO should develop ties with ABEPF and take an important role in providing up-to-date, concise information (i.e., continuing education materials and technology up-dates) on reproductive health to service providers, including former trainees. From a strategic point of view, JHPIEGO should continue to provide technical support to these service providers. Spare parts for laparoscopic equipment, particularly silastic bands for tubal occlusion, should also be provided as part of a technical support package for former trainees.**

5.5.2 Relationship with Implementing Agencies

JHPIEGO's current relationship with CPAIMC is also only fair. For many reasons, of which the gradual withdrawal of A.I.D. funds is particularly significant, the institution is in a state of flux. In the current difficult climate for VSC, CPAIMC senior management have a sense of isolation, a feeling that the organization paid a very high price (in terms of its public image) for its pioneering work in this method and that A.I.D. and its CAs are no longer available to bolster its efforts.

JHPIEGO maintains a good relationship with BEMFAM. The sense of isolation felt at CPAIMC, however, is also beginning to be felt at BEMFAM. Partly responsible is the JHPIEGO decision to terminate its funding for training of CHWs (see Section 3.1.1). BEMFAM staff are also apprehensive about the recent decision that physicians cooperating with BEMFAM services are to be trained at SAMEAC, the public sector PAISM training center that JHPIEGO plans to support in Ceará. BEMFAM staff feel as if JHPIEGO is deserting their project because their physicians will have to compete with government training candidates for limited training openings. BEMFAM fears that its physicians will not receive the training opportunities they need to continue implementation of the reproductive risk project.

5.5.3 Relationship with Local A.I.D. Representative's Office

The A.I.D. office in Brasilia has a good relationship with JHPIEGO. The A.I.D. Representative lists among JHPIEGO's strong points its preparation of project proposals and project administration. Coordination in some areas, however, could be improved.

5.5.4 Relationship with Official Organizations

As JHPIEGO prepares for initiation of training projects with the public sector, it has taken particular care to coordinate its plans with other international organizations working with the MOH. The World Bank, UNFPA, and the Pan American Health Organization, in particular, have been fully informed of, and participated in, planning meetings for the training centers.

5.5.5 Overlapping Mandates and Relationships with Other A.I.D. CAs

JHPIEGO's mandate overlaps with that of a number of other CAs operating in Brazil. On the whole, this redundancy has been advantageous, as it has allowed CAs flexibility in meeting institutional needs. The only instances in which overlap has been a problem have occurred when CAs have not coordinated their activities among themselves.

On the other hand, defining mandates too rigidly could cause problems. A stricter enforcement of JHPIEGO's mandate, ruling out any training of CHWs, resulted in its withdrawing from CHW training in two states in the BEMFAM project (see Section 3.1.1). Likewise, the strict adherence to JHPIEGO's mandate would make it impossible for JHPIEGO to carry out Recommendation 26 in this report (calling for team training, including for various non-clinical personnel).

Development Associates

Like JHPIEGO, DA trains family planning nursing personnel. This has not created problems. For example, in the mid-1980s, activities were well coordinated between JHPIEGO and CPAIMC; nurses received clinical and surgical training in the same course, during which DA covered the costs of clinical training and JHPIEGO covered the costs of surgical training.

DA has actively participated in the planning process with the MOH/CORSAMI. In the project, JHPIEGO will be primarily responsible for physician and nurse (university degree) training, and it has encouraged DA to take an active role in planning for auxiliary nurse training. Cooperation has been excellent.

The Pathfinder Fund

Pathfinder trains physicians in IUD insertion and VSC, as does JHPIEGO. Both are cooperating in order to avoid overlap of activities in Brazil and consequently not to have a negative effect in the field. Most recently, the area of possible overlap is the Pathfinder-funded project with FEBRASGO to be implemented in the Northeast at selected Brazilian medical schools. As designed, the FEBRASGO project will, among other activities, train medical professors in family planning training methodology and provide supplies and materials to medical-school-based family planning programs. In-service physician training, with emphasis on IUD insertion, would also be provided at selected medical schools in the Northeast. Pathfinder and JHPIEGO have held discussions in order to avoid overlap with the JHPIEGO project under negotiation with the MOH, since the majority of PAISM training centers are medical-school-based. The result of the discussions has been that Pathfinder will concentrate its efforts on pre-service training and JHPIEGO will focus on in-service training at medical schools.

Even under this arrangement, it is likely that there will be a few medical schools in which Pathfinder will be supporting pre-service training and JHPIEGO will be assisting in-service training. Most likely, the trainers will be the same individuals for both types of training. Unless Pathfinder and JHPIEGO coordinate service standards, training methodology, and content, confusion could result.

Association for Voluntary Surgical Contraception

AVSC trains physicians in VSC, as does JHPIEGO. Despite this overlap, problems have arisen only from lack of coordination, not from the existence of overlap.

In the early 1980s, activities between the two organizations were well coordinated: JHPIEGO supported training, with an emphasis on VSC and equipment RAM services, while AVSC provided support for VSC service delivery. As AVSC began to train in minilaparotomy, problems arose because each originally used different training standards. For example, JHPIEGO initially supported minilaparotomy training at CPAIMC, utilizing the minilap pistol for application of Silastic bands. At the same time AVSC was supporting minilaparotomy training and services at ABEPF affiliates with emphasis on the traditional ligation method, which does not rely on expensive, imported supplies. Consequently, Brazilian family planning organizations received a confusing double message regarding the most appropriate tubal ligation technique for minilaparotomy. In another instance — when AVSC also took the lead in trying to encourage Brazilian family planning organizations to discontinue use of ultraviolet light for the sterilization of JHPIEGO-donated laparoscopes (see Section 4.1.2) — JHPIEGO did not become involved in the debate, leaving an opening for AVSC to step in. JHPIEGO should have played a more active role in educating physicians about appropriate equipment sterilization techniques for its donated laparoscopes.

Recommendations

- (36) **Overlap in mandates should exist to allow JHPIEGO and other CAs flexibility in meeting institutional needs.**
- (37) **In general, JHPIEGO needs to strengthen cooperation with other CAs operating in Brazil, particularly those with overlapping mandates.**

5.5.6 Relationship between JHPIEGO and Johns Hopkins University

A main JHPIEGO strength lies in its affiliation with The Johns Hopkins University (JHU). In contrast, one of its weaknesses is that JHPIEGO does not draw upon the vast technical skills of the JHU Schools of Medicine, Nursing, and Hygiene and Public Health.

Those who have been trained at JHPIEGO/Baltimore are surprised to find that JHPIEGO is not more closely associated with the medical school and that its staff have few, if any, links to the university. It is assumed that there are strong ties between JHPIEGO and the JHU School of Medicine and between JHPIEGO and other A.I.D.-supported projects at JHU, particularly the Population Communication Services (PCS) project.

Local institutions perceive that, although JHPIEGO uses its university affiliation to gain prestige, no technical support is actually provided by the university for field operations. Brazilians think that there is a fund of technology and methodology inside the university that could be transferred to Brazilian institutions via JHPIEGO — but is not.

Recommendation

- (38) **JHPIEGO's ties with the university should be strengthened either by recruiting JHU faculty as part-time JHPIEGO staff or consultants or by arranging for JHPIEGO staff to become part of the faculty.**

Appendix A
Assignment Background

Appendix A

Assignment Background

The purpose of this evaluation was to assess JHPIEGO activities in Brazil (see Attachment 1 for scope of work). Evaluation findings will be incorporated within a larger evaluation of JHPIEGO projects in other countries to be presented to A.I.D. and JHPIEGO.

The evaluation was conducted during the months of April through September 1991. Site visits were made in July 1991 to BEMFAM service sites in Rio de Janeiro, Ceará and Pernambuco. Government and other officials were also contacted in Brasilia in July 1991. A complete list of individuals interviewed for purposes of the assignment is found in Attachment 2.

The evaluation was conducted by Karen Johnson Lassner, an international public health consultant, who has lived and worked in Brazil for 15 years.

Attachment 1

Scope of Work

B. PROJECT PLANNING PROCESS

The Latin America office at JHPIEGO developed a model to be used for planning for reproductive health sub-project development.

1. How effective and useful is JHPIEGO's current model for its work in Brazil?
 - o Would a more comprehensive model and strategy be more effective and useful for JHPIEGO?
 - o What would be included in such a model?
2. How well does JHPIEGO's work fit into Brazils' family planning organizations' training strategy?
3. How should JHPIEGO prioritize their strategies to meet the perceived needs and to maximize impact? (Include at least the following):
 - pre-service education for doctors
 - pre-service education for nurses and mid-wives
 - in-service training
 - private sector development
 - use of reproductive risk classification for paramedics
 - long-term methods like VSC, IUD and NORPLANT
 - education in genital tract infection management
 - distance learning
 - laparoscopy equipment maintenance support
 - o Are there other strategies that would be appropriate for JHPIEGO?
4. Are projects planned with enough attention to the sustainability of the project? (E.g., has CPAIMC sustained its role in family practice personnel training?) Are there changes that should be made to increase sustainability?
5. Are small scale projects like that with BENFAM planned with enough attention to later expansion to a larger scale?

C. PROJECT IMPLEMENTATION

This section is very important, if the information is readily available. Both quantitative and qualitative data are useful.

Training

1. What has the impact been on quantity and quality of service of the following:
 - training of trainers (CPAIMEC)
 - in-service training
 - reproductive risk classification for paramedics
 - emphasis on long-term methods (VSC, IUD and NORPLANT)
 - education in genital tract infection management
 - the equipment maintenance center
2. Is JHPIEGO providing sufficient support and follow-up to its training projects? If no, what kind of additional support and follow-up are needed?

Target Audience

1. Is JHIEGO reaching the future providers of FP services? Are the trainees using the training in FP education, administration or service delivery? What can be done to ensure that trainees are used to further FP?
2. What are the educational and training needs of the different FP target audiences? (Note: JHPIEGO shifted from laparoscopy to minilap/IUD after an evaluation around 1981 showed need for this shift. After 10 years of training in minilap/IUD what are the current needs?) How effective is JHPIEGO in meeting these needs?

Institutional Development

1. How effective has JHPIEGO been at institutionalizing FP/RH training into the training institutions of Brazil? How can JHPIEGO improve its efforts to institutionalize?
2. How useful for the training institutions is JHPIEGO's method of curriculum development?
3. Regarding possible future expansion, is FP/RH seen by Brazil's educators as an important and integral part of medical/nursing education?

Educational Materials

1. Are trainers using educational materials appropriately?
2. Which materials are most helpful and to whom?

D. EVALUATION PROCESS

This is a high priority section for both ST/POP and the missions, which are interested in measuring the impact of educational and training projects on quantity and quality of service provision. In addition, ST/POP is interested in disseminating the lessons learned from its projects to the broader development community.

1. How does JHPIEGO measure impact, quality, and "need to know?"
 - o How effective has JHPIEGO been in examining the quality, relevance and impact of their various training activities?
 - o What would be other meaningful and obtainable indicators of quality, relevance and impact?
 - o How have evaluation results been used to improve the project work?
2. How can JHPIEGO better build evaluation into its projects?
 - o Are the tools JHPIEGO is currently using sufficient to evaluate the support they are providing? Are there other tools they should be using?
 - o Do the local project directors evaluate their projects? How? How can this process be improved?
3. How feasible are indicators linked to service delivery (e.g. number of new acceptors or measurements of quality of care)?
4. What special evaluation studies should JHPIEGO embark on given their activities?
 - o What topics for publication or presentation at local, national and international conferences should JHPIEGO be developing?

E. OTHER CONCERNS

COLLABORATION WITH OTHER INSTITUTIONS

1. How is JHPIEGO's relationship with government and local institutions (e.g. MOH, MOEd, professional bodies, educational and FP institutions)?
2. How is JHPIEGO's relationship with its implementing agencies?
 - o What has the impact been of JHPIEGO's using local professionals as in country sub-project directors?
 - o What are the advantages and disadvantages?
3. How is JHPIEGO's relationship with the local mission?
4. Is there a need to clarify mandates between JHPIEGO and other cooperating agencies?
 - o Have problems with overlapping mandates negatively affected work in the field?

REPRODUCTIVE RISK AND LAPAROSCOPY EQUIPMENT MAINTENANCE

An evaluation of JHPIEGO's project with BENFAM is planned so this area should be assessed with that in mind. It would be useful to suggest issues to be examined in depth by the later evaluation and to suggest ways that BENFAM can better evaluate and monitor the impact of the project.

1. What has the impact been of using the reproductive risk classification and referral system for paramedics at BENFAM?
2. How is this system being monitored by BENFAM and JHPIEGO? How can the monitoring be improved?
3. How well are BENFAM's paramedics assessing reproductive risk? How well does their classification compare to that of health professionals? Which group does better?
 - o What do clients say about the quality of their care from BENFAM's paramedics who have been trained by the project?
4. How well is laparoscopy equipment being maintained by CPAIMC institutions?
 - o What are the problems in sustaining the equipment maintenance center, if any?
 - o What are the costs of the program and can they be sustained by CPAIMC?
 - o What can CPAIMC, JHPIEGO or the mission do to improve equipment maintenance?

Attachment 2

List of Persons Interviewed

Implementing Agencies and Trainees

Rio de Janeiro

Ms. Carmen Gomes, Executive Secretary, BEMFAM
Dr. Ney Francisco P. Costa, Coordinator, Medical Department, BEMFAM
Ms. Ana Gloria Pires, State Coordinator, BEMFAM
Ms. Lia Kropsch, former Executive Director, CPAIMC
Ms. Maria Fatima Augusta Paz, CHW & President, Centro Comunitario Augusto Paz
Dr. Teresa Cristina de Lima Lewin, BEMFAM physician, Sociedade de Amigos Vila Kennedy,
Dr. Vania Lucia Bastos, chief physician, Clinica do Meier, BEMFAM
Dr. Valeria Bravo Carneiro, physician, Clinica do Meier, BEMFAM
Dr. Paulo, physician in training at BEMFAM's Clinica do Meier

Pernambuco

Ms. Denise Zelaquett P. Barbosa, State Coordinator
Ms. Maria Jose Bezerra da Silva, Community Supervisor
Ms. Catarina Marcia da Silva, Community Supervisor
Ms. Marineide Teixeira Neves, Community Supervisor
Ms. Ubiracira Lima Cruz, Community Supervisor
Dr. Ivo Queiroz Costa, Mayor, Vitoria de Santo Antao
Dr. Edvaldo Bioni, physician, APAMI, Vitoria de Santo Antao
Ms. Maria do Socorro Alvarez Queiroz, President, APAMI, Vitoria de Santo Antao
Ms. Marluce Maria da Silva, Treasurer, APAMI, Vitoria de Santo Antao
Ms. Rosa Maria da Sila, CHW, Vitoria de Santo Antao
Ms. Mauriceia Miranda, CHW, Vitoria de Santo Antao
Ms. Sheila, Director, Social Services Division, Municipal Secretariat of Health, Vitoria de Santo Antao
Dr. Jane de Fatima Andrade dos Santos, Municipal Secretary of Health, Abreu e Lima
Dr. Leilane Cunha, physician, Joao Ribeiro Health Post, Abreu e Lima
Ms. Fatima Aparecida Carneiro da Silva Campelo, CHW, Joao Ribeiro Health Post, Abreu e Lima
Ms. Diana Vandaliza de Oliveira, Director of Planning, State Secretariat of Health
Ms. Maria Anita de Souza, State Manager for the Northeast Project, State Secretariat of Health

Ceará

Ms. Aldamara de Souza Costa, BEMFAM State Coordinator
Ms. Maria Edileusa Calado Luz, BEMFAM Training Coordinator
Ms. Maria Auxiliadora de Moraes, BEMFAM, JHPIEGO Project Supervisor
Dr. Edna Vasconcelos de Mesquita, physician, BEMFAM clinic
Dr. Silvia Bomfim, Director of Ambulatory Care, SAMEAC
Dr. Antonio Machado Barbosa, physician, Del Rio post
Ms. Maria das Gracas M. da Silva, auxiliary nurse/CHW, Del Rio Post
Ms. Dorimar Vasconcellos, social worker, Del Rio factory
Ms. Maria Gorete Campos, Administrator/CHW, Casa Maternal Francisco de Abreu
Dr. Regina Coeli Menezes Moreira, physician, Casa Maternal Francisco de Abreu
Ms. Maria da Penha Silva, CHW, Municipal Hospital, Campos Salles
Dr. Jay McAuliffe, Director, Project Hope, Fortaleza

Minas Gerais

Dr. Antonio Aleixo Neto, OB/GYN professor, Federal University of Minas Gerais

Parana

Dr. Rosires Pereira de Andrade, professor of human reproduction, Federal University of Parana

Professional Associations

Ms. Denise das Chagas Leite, Executive Director, ABEPF

Ms. Conceicao Rocha Pinto, VSC & Training Coordinator, ABEPF

Dr. Jose Weydson de Barros Leal, President, SBRH; Past President, FEBRASGO

Ministry of Health

Dr. Jose Formiga, Director of Family Planning, CORSAMI

International Organizations

Mr. Pedro Pablo Villanueva, Country Director, UNFPA

Dr. Horacio Toro, PAHO Consultant to PAISM

USAID

Mr. Howard Helman, USAID Representative, Brasilia

Ms. Joanne Jones, Assistant to USAID Representative, Brasilia

Cooperating Agencies

Ms. Christina Barros, Brazil Project Officer, Development Associates, Inc.

Mr. Fernando Gomez, Regional Director for LAC, AVSC

Dr. Jose de Codes, Representative in Brazil, Pathfinder International

JHPIEGO

Dr. Noel McIntosh, Director

Ms. Sandra de Castro Buffington, Associate Director, LAC

Appendix B
Laparoscopy Equipment Maintenance

Appendix B

Laparoscopy Equipment Maintenance

Since the external evaluation of JHPIEGO activities in Brazil was contracted, the JHPIEGO equipment officer has conducted a complete evaluation of the status of laparoscopic equipment RAM activities. (See JHPIEGO Trip Report, Brazil, May 20 - June 4, 1991, by Chung Oh.) The following comments are intended to complement and reinforce Mr. Oh's evaluation.

USAID has donated 321 laparoscopic equipment systems to Brazilian institutions, 307 of which have been donated via JHPIEGO. Since the investment has been considerable and many institutions rely on this equipment for provision of VSC and infertility services, JHPIEGO should continue to provide RAM services in Brazil.

Due to the numerous institutional difficulties that CPAIMC has faced in recent years, it has been unable to maintain the high quality of equipment maintenance and repair services that it previously provided. The major problem has been the lack of funds to cover the maintenance technicians' salaries, as income generated by RAM center services have not been sufficient to do so. CPAIMC is currently uncertain as to whether it plans to continue to be involved in RAM activities.

The consequences of not providing RAM services can have a detrimental effect on the safety of VSC services provided at Brazilian institutions. Since RAM services at CPAIMC began to falter and silastic bands have not been available (or have been available for sale only), ABEPF reports an increase in the use of cauterization for laparoscopic tubal occlusion. Recently, of 906 laparoscopies reported in one month to ABEPF, 40 had utilized cauterization. (In the past, reporting of cauterization for tubal occlusion was negligible.) Also, the ABEPF Ethics Committee reviewed the case of an institution that was providing VSC services with a broken laparoscope.

Several problems with respect to laparoscopic equipment can be identified. First, for the equipment to remain operational, at the very minimum a continuous supply of silastic bands must be available. One of the RAM center's most requested services is to supply silastic bands, which is not a repair or preventive maintenance activity and does not require a trained technician. Second, demand is low to moderate for spare parts (in addition to silastic bands) and very low for repair services, as institutions repair and replace spare parts themselves. There is no demand for preventive maintenance. Thus, RAM center activities do not occupy the full-time efforts of a technician. Third, a number of institutions indicate they are unable to purchase repair and spare parts. It is not clear exactly which institutions are indeed unable to pay and which institutions are unwilling to pay.

In order to continue providing RAM services in Brazil, JHPIEGO should separate the repair and maintenance functions, including provision of small parts, from the supply of silastic bands. To supply bands, USAID could arrange for their distribution in the same manner as contraceptive commodities. In Brazil, for example, Pathfinder could be designated as the distributor using the same distribution criteria it uses for donations of commodities. Alternatively, ABEPF could be contracted to distribute silastic bands (and spare parts), since it has experience in providing supplies and materials to family planning organizations throughout Brazil. In fact, almost all of its 130 affiliates have JHPIEGO-donated equipment

For repair and maintenance, including provision of spare parts, a hospital that has donated JHPIEGO equipment and that also has a hospital equipment center in operation could be identified and the technician trained to provide RAM services for laparoscopic equipment. Several institutions fit this description. If JHPIEGO hires an in-country representative or project coordinator for Brazil, the local office could also be responsible for dispatching small parts, fielding requests for repair and maintenance, contracting technicians on a fee-for-service basis, and evaluating the contribution to be made by each organization for spare parts and services provided.

Recommendations

- (1) **The laparoscopic equipment repair and maintenance function should be separated from the supply of silastic bands function.**
- (2) **JHPIEGO should identify an institution that already has a medical equipment repair and maintenance center in order to service JHPIEGO-donated laparoscopic equipment.**
- (3) **JHPIEGO should identify an institution that already distributes contraceptive supplies to be responsible for supplying silastic bands for JHPIEGO-donated laparoscopic equipment.**

Appendix C
List of Recommendations

Appendix C

List of Recommendations

- (1) JHPIEGO should monitor BEMFAM training and service provision processes more closely in order to identify areas for technical support. Greater medical supervision should be provided by BEMFAM to the project.⁵
- (2) BEMFAM supervisors need specific training in supervision of clinical services in order to become familiar with the programmatic areas in a clinical program that they should oversee. Medical leadership at the state level also should be strengthened in order to provide necessary technical backup to the supervisors.
- (3) **In the BEMFAM project, reproductive risk should be emphasized as an important concept and tool but not as the main focus of the project (unless MOH policy changes permitting referral of only at-risk women to the physician). CHW activities should be redirected from emphasis on reproductive risk classification to IEC.**⁶
- (4) **JHPIEGO and other USAID CAs need to address the lack of information and the misinformation surrounding the IUD, particularly in Brazil's Northeast.**
- (5) JHPIEGO-supported projects must seek ways to assure sufficient IUD cases to achieve training competency (see Recommendation 17 regarding use of anatomical models to supplement training on actual IUD cases).
- (6) **JHPIEGO's early work in pre-service training should be re-activated and coordinated with other CAs, particularly with Pathfinder. Priority attention should be placed upon promotion of activities that will contribute to policy formation and change in order that reproductive health be officially included in the curricula of schools of medicine, nursing and social work. The next priority should be training of trainers in reproductive health and appropriate educational technology.**
- (7) JHPIEGO should continue its efforts to initiate training assistance for the public sector women's health care program, PAISM. Support needs to be provided for training of trainers at MOH-designated training centers and other state or municipal training programs designed to implement PAISM. JHPIEGO assistance should be coordinated with other international donors that are now considering focusing their support on specific states and/or municipalities to assure PAISM implementation in these areas.
- (8) **JHPIEGO should continue to support private sector family planning training. Prime emphasis should go to continuing support for integration of the BEMFAM community program because of its significance in expanding public sector family planning services, particularly in the Northeast. JHPIEGO should also expand its activities to the five remaining Northeast states where it has not previously provided training support.**
- (9) JHPIEGO should look to the private non-profit sector as an important partner in expanding reproductive health services in Brazil, and as such, dedicate considerable effort to strengthening private sector institutional relationships. Thus, JHPIEGO should support training of trainers and,

⁵Recommendations 1 through 5 are pertinent only if the BEMFAM effort continues, as recommended in Recommendation 8.

⁶Recommendations that appear in boldface type are the principal recommendations in this report.

when appropriate, in-service training at private institutions that present opportunities to transfer training and service technology to the public sector and other private sectors institutions.

- (10) JHPIEGO's application forms need to be reviewed and modified as a means of improving the selection process. Field visits could be used to assist in trainee selection.
- (11) As JHPIEGO plans training projects with the public sector, particular attention should be focused on trainee selection to ensure that trainees will work in family planning.
- (12) During project implementation, JHPIEGO should provide stronger technical support, particularly in the areas of curriculum development, teaching skills, and clinical skills (specifically infection prevention and anesthesia for VSC).
- (13) Post-training field visits should be made to help ensure that training is utilized in service implementation and to provide such support as equipment and supplies, scientific publications, and training for other staff members (i.e., other team members such as nurses, auxiliaries, and even other physicians). Post-training support in the public sector should be coordinated by state secretariats of health who are primarily concerned that personnel trained in the state training centers actually utilize their training.
- (14) In order to identify areas for technical support, JHPIEGO should attempt to improve its monitoring process by dedicating greater effort to assessment of the training and service provision processes.
- (15) JHPIEGO should provide educational materials in Portuguese covering service standards, training (with need-to-know information), and case studies.
- (16) In addition to equipment (such as IUD and minilap kits), all trainees should receive some type of IEC material — preferably a flip chart.
- (17) All trainers should receive instruction in the use of anatomical models for training. JHPIEGO should also supply all training centers with models not only for IUD insertion but also for diaphragm fitting.
- (18) In order to strengthen strategy formulation, project planning and implementation, and programming of technical support for Brazil, JHPIEGO should contract an in-country representative/project coordinator.
- (19) Training of trainers in reproductive health, whether for pre- or in-service training, should provide trainers with clinical skills and with the teaching skills and educational technology necessary to achieve training-to-service standards. The importance of providing training in reproductive health within the context of women's health care should be stressed. Humanistic teaching techniques (i.e., the use of anatomic models) and the team approach should also be included in training.
- (20) All JHPIEGO-supported physician training, both pre- or in-service, should include provision of contraceptive services within the context of women's health care. All contraceptive methods should be emphasized equally. Training in minilaparotomy should be resumed and provided along with training in other methods. Training in laparoscopy, due to its dependence on expensive, imported supplies, should be conducted only in special circumstances (e.g., the institution has the equipment but no one is trained to use it).

In addition to the standard curriculum, training for Brazilian physicians should emphasize contraceptive counseling, quality of care, prevention of infection, and the human element in providing health care. Genital tract infection identification and management will require considerable training effort.

- (21) Separate specialized training should be made available to providers who have already received basic training in reproductive health but whose training did not include specific methods or content areas. Their training either should include family planning (including VSC) counseling, management of genital tract infections, prevention of infection, quality care, Norplant, immediate post-partum IUD insertion, post-partum minilaparotomy, and vasectomy.
- (22) JHPIEGO-supported public sector training should stress maternity-based family planning (post-partum and interval management of all contraceptive methods, including VSC when politically feasible) integrated with other PHC actions.
- (23) For practice training, an institutional approach should be taken that would evaluate training needs based on the staffing patterns of the trainees' institutions and that would designate clinical and/or surgical training accordingly.
- (24) Both pre- and in-service training for nurses should include both service provision and family planning service management. At the current stage of family planning services development in Brazil, nurse training in family planning clinic management should emphasize service implementation — that is, how to initiate family planning service provision in a given institution.
- (25) Didactic training for nurses and nursing students should emphasize, in addition to clinical skills, family planning information and counseling, quality of care, and the human element in provision of care.
- (26) JHPIEGO should take an institutional approach to training — that is, training trainers to train teams of physicians, nursing personnel, CHWs, social workers, and other professionals to implement services. This might require a broadening of JHPIEGO's mandate.
- (27) Training for the social workers, psychologists, and social scientists who are involved in identifying potential family planning clients should be both didactic and practical. Considerable emphasis should be placed on implementation of family planning services, service standards, the various methodologies for service delivery (for example, maternity-based, employment-based, community-based), information and counseling, quality of care, and integration of family planning with other health and social services. This information should be provided to social workers during their pre- and in-service training. For other similar professionals, it should be provided in-service.
- (28) JHPIEGO must make sure that training centers offer ample opportunity for practice training (e.g., as in municipal and state health centers and maternity hospitals and NGOs). This will be particularly important in the PAISM effort. With respect to pre-service training for medical and nursing students, JHPIEGO should support such training only at schools that can offer practice training in real-life situations.
- (29) JHPIEGO headquarters staff needs to be enlarged, and greater staff technical support needs to be provided in education and training. The level of reinforcement needed will depend on whether a local representative is hired (see Recommendation 18) and the degree to which local consultants are used.

- (30) **Project planning must become a more dynamic process which is based on up-to-date country-specific strategies that are coordinated with overall USAID strategies. Institutional capacity needs to be carefully assessed during the project planning process in order to program technical support. Projects should be replanned as strategies or policies change.**
- (31) **Due to the impossibility of collecting quantitative provider data, the APS should be discontinued or considerably revised to allow for collection of qualitative data from a representative sample of trainees or institutions.**
- (32) **Special impact evaluation should be the methodology of choice of all JHPIEGO-supported training projects in Brazil and should focus on service quality as opposed to quantity.**
- (33) **The results of the BEMFAM impact evaluation must be widely disseminated in Brazil, particularly in the public sector.**
- (34) **JHPIEGO should develop ties with Brazilian physician and nursing professional associations, the MOEd, and schools of medicine, nursing, and social work.**
- (35) **JHPIEGO should develop ties with ABEPF and take an important role in providing up-to-date, concise information (i.e. continuing education materials and technology up-dates) on reproductive health to service providers, including former trainees. From a strategic point of view, JHPIEGO should continue to provide technical support to these service providers. Spare parts for laparoscopic equipment, particularly silastic bands for tubal occlusion, should also be provided as part of a technical support package for former trainees.**
- (36) **Overlap in mandates should exist to allow JHPIEGO and other CAs flexibility in meeting institutional needs.**
- (37) **In general, JHPIEGO needs to strengthen cooperation with other CAs operating in Brazil, particularly those with overlapping mandates.**
- (38) **JHPIEGO's ties with the university should be strengthened either by recruiting JHU faculty as part-time JHPIEGO staff or consultants or by arranging for JHPIEGO staff to become part of the faculty.**

Recommendations from Appendix B

- (1) **The laparoscopic equipment repair and maintenance function should be separated from the supply of silastic bands function.**
- (2) **JHPIEGO should identify an institution that already has a medical equipment repair and maintenance center in order to service JHPIEGO-donated laparoscopic equipment.**
- (3) **JHPIEGO should identify an institution that already distributes contraceptive supplies to be responsible for supplying silastic bands for JHPIEGO-donated laparoscopic equipment.**