



USAID

SUPPORT FOR FAMILY PLANNING  
& REPRODUCTIVE HEALTH  
PROGRAMS IN

*Brazil*



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PANAMA

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# SUMMARY

The United States Agency for International Development (USAID) supported family planning and reproductive health programs in Brazil for more than 30 years.

From 1992 to 2000, the final years of this program, USAID concentrated the majority of its activities in two states, Bahia and Ceará, in the poorer northeastern region of Brazil where indicators showed a lag in women's and men's reproductive health status. The final strategy also made clear USAID's intent to phase out support for family planning in Brazil by 2000 when all activities would need to be self-sustaining. While USAID's programs and initiatives in Brazil have been numerous, this report summarizes USAID's financial and technical support for family planning and reproductive health, focusing on the principal activities that took place between 1992 and 2000.

Over the years, USAID programs in Brazil helped establish a supportive and energized environment for family planning and reproductive health activities. The policy environment clearly improved, which should contribute to a strong, continuing program following USAID's phase-out. USAID's assistance in research and data collection has increased the quality and credibility of reproductive health information for policy, planning, and program evaluation. USAID's support for the introduction of new contraceptive methods has broadened the range of methods available to women, although the use of new methods is still low. The phase-out strategy tapped into the resources and networks of the

private, commercial sector, helping expand the range of methods and lower the cost of commodity procurement for the public sector.

In addition, by the end of 2000, BEMFAM—the first family planning organization to receive USAID assistance in the 1960s—succeeded in reorienting its program and financial strategies to become nearly self-sufficient. Perhaps one of the most remarkable successes, given its relatively late start in 1996, was PROQUALI, a new client-focused model of service delivery for the public sector. In the two states where it has been implemented, PROQUALI has dramatically improved the delivery of family planning and reproductive health services, and offers significant potential for further expansion.

A number of lessons can be drawn from the experiences of the various agencies that USAID supported in Brazil over the years. Many of these lessons relate to the importance of local partners investing their own human and financial resources in program activities. The USAID-supported agencies also emphasized the importance of a clearly defined phase-out strategy with adequate time for implementation.

For the immediate future, it will be critical to identify additional opportunities for expanding many of the innovative and successful initiatives started with USAID support. This report is intended to assist interested organizations in understanding the major achievements of and lessons learned from USAID's activities in Brazil and to identify opportunities for future investment.

# INTRODUCTION

USAID led the introduction of donor support for family planning in Brazil in the late 1960s and remained the major donor for reproductive health assistance for more than 30 years, until the program's phase-out in September 2000.

During these three decades, the program experienced shifts in overall strategy, program design, and funding, as well as successes and failures.

USAID support for family planning and reproductive health programs in Brazil can be divided into three distinct periods. The first period was the longest phase of support, from the late 1960s until 1988. The program then had a transition phase from 1989 to 1992 as it began to reshape

its focus. The final phase lasted from mid-1992 to September 2000. For the final period, USAID shifted its program emphasis and clearly stated the agency's intent to phase out program support for family planning in Brazil by September 2000.

This report briefly summarizes the early periods of USAID support and highlights the major accomplishments during the final phase of the program. It is designed to provide program managers, policymakers, and international donors with insights on program achievements and lessons learned, and to identify opportunities and models for future replication and expansion both within Brazil and in other countries.

# THE *B*RAZILIAN CONTEXT

**B**razil is the largest country in Latin America—its population of 168 million represents almost one third of the entire population of Latin America and the Caribbean.

The country is highly urbanized, with approximately 80 percent of the population residing in urban areas and a large portion of that figure residing in the more industrialized southeast region (São Paulo, Rio de Janeiro, and Belo Horizonte). Brazil's per capita gross national product of US\$4,630 is slightly lower than the average for other upper-middle-income countries, but higher than average for the region. Despite its relatively high national income level, Brazil still lags behind other countries in the region in key social indicators such as infant mortality. This is due in part to Brazil's dramatic regional differences. For example, per capita income in Brazil's richest state, São Paulo, is seven times the per capita income in Piauí, the poorest state. Such income gaps also exist between the rich and the poor in urban areas.

Between the early 1960s and late 1990s, Brazil experienced dramatic social and demographic changes. The population growth rate decreased from 3 percent annually in the 1960s to 1.3 percent in the 1990s. The average number of births per woman declined from six to 2.4, and, most dramatically, the percent of women in union using contraception increased from approximately

10 percent in the early 1960s to 77 percent in 1996.<sup>1</sup> The demographic transition was underway in the more prosperous urban centers of the Southeast as early as the 1960s. However, it was not until the 1980s that the process began to take hold in the North and northeastern regions. Even today, the rate of demographic change in large areas of the rural North lags far behind the rest of the country.

The Brazilian health care system has also seen dramatic changes in the last two decades. The return to civilian government in the 1980s started a major re-examination of Brazil's health care system. The Constitution of 1988 guaranteed free, essential health care to all members of the population—something that the existing health care system was clearly failing to deliver. To achieve greater equity and efficiency in the allocation of resources, the government developed the Unified Health System (SUS). Part of the reform process was to gradually decentralize health care service delivery by turning over facilities and staff to municipalities and promising financial support through revenue-sharing schemes. Unfortunately, these changes took place at a time when the macroeconomic and fiscal conditions in the country were deteriorating. As a result, the SUS continued to have difficulties and, after almost a decade of experience, the poor were even less well-served and spending more out-of-pocket for health care and medicines than before the system was launched.<sup>2</sup> Since 1994, the Brazilian Government has been working to revamp the SUS model, expanding attention to primary care and trying to improve responsiveness to the needs of lower-income groups.

The demand for family planning services has expanded rapidly in Brazil. According to the 1996 Demographic and Health Survey (DHS), 77 percent of women in union use contraception. Sterilization



is by far the most prevalent method, used by 42.7 percent of women, despite the fact that until 1997 tubal ligations were illegal but generally provided covertly in conjunction with Caesarean-section deliveries. Oral contraceptives are the second most widely used method at 20.7 percent.<sup>3</sup> The public sector is the primary provider of permanent contraceptive methods. Public health facilities or private hospitals that are members of the Unified Health System provide about 71 percent of female sterilizations. Private pharmacies are the primary source for oral contraceptives (approximately 90 percent according to the 1996 DHS). The rapidly increasing demand for family planning services is attributed to a number of factors—rapid urban and metropolitan growth, increased education, and changes in women’s roles.

Women’s health activists began promoting a comprehensive reproductive health package in

(ICPD). Interestingly, the ICPD endorsed a framework for reproductive health, including family planning, that had already been defined in Brazil. However, political and economic turmoil in the late 1980s and early 1990s prevented the Brazilian Government from implementing PAISM.

In 1994, with increasing economic stability and the commitment of a new government, Brazil began to implement a family health service package that incorporated the PAISM model. As a result, municipal-level primary care services have increasingly integrated reproductive health services, including family planning. Prenatal and maternity care have also improved, and the prevention and treatment of sexually transmitted diseases (STDs) are better integrated.

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the early 1980s. In 1984, the Ministry of Health developed the Comprehensive Women’s Health Program (Programa Assistência Integral à Saúde de Mulher, or PAISM), which incorporated many of the elements of reproductive health called for a decade later at the 1994 International Conference on Population and Development

The financing of health care remains problematic and the decentralization of services has generated new political problems. In many settings, clients continue to be poorly treated in the public health system. There are also inequities in access to services and distortions in the allocation of resources that benefit higher-income users.

## OVER *J* HIRTY YEARS OF USAID SUPPORT

**U**SAID's support for family planning in Brazil began in the late 1960s with assistance to the newly created family planning organization, BEMFAM, through the International Planned Parenthood Federation (IPPF).

BEMFAM became an official IPPF affiliate in 1967. In the late 1960s and 1970s, USAID's support expanded to include other nongovernmental organizations (NGOs) providing family planning services, the training of health care providers, and basic demographic and operations research. For many years, USAID's support continued to focus on NGO and university activities. This strategy was consistent with USAID's overall assistance program that concentrated on strengthening Brazilian organizations and developing "centers of excellence." During this period, the United Nations Population Fund (UNFPA) and the Ford Foundation were the only other consistent sources of funding for family planning activi-

ties. In 1975, USAID closed its development assistance program in Brazil, although a development attaché at the U.S. Embassy continued to manage the family planning program.

As Brazil's economy deteriorated in the 1980s, USAID reopened its office in 1985 to provide support to Brazilian institutions working on several "key" global problem areas—HIV/AIDS, global warming, and family planning. With Brazil's transition to democratic rule, USAID began to develop a broader strategic focus for its family planning activities to include the public and private commercial sectors. However, U.S. Congressional restrictions on foreign assistance did not allow USAID assistance to be provided directly to the Brazilian federal government because of Brazil's late payment of foreign debt and failure to sign the Nuclear Nonproliferation Treaty. Assistance could only be provided to NGOs, the private commercial sector, and state-level governments. During this period,



the program focused on developing a more positive policy environment for family planning, supporting basic demographic and operations

to encourage the NGOs that it had supported for many years to begin developing sustainability plans. Many of these organizations did not survive

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research, and strengthening service delivery through commodity assistance, training (again primarily for NGOs), and the development of educational materials for providers and clients.

From 1989 to 1992, USAID began to gradually shift its program focus for family planning and reproductive health. After 20 years of military rule ended in 1984 and as the democratic government began to take hold, USAID began considering new ways to provide family planning assistance in Brazil. The 1986 DHS survey—the first conducted in Brazil—provided important national data on the reproductive health status of Brazilians, highlighting the stark differences in health status among the richer and poorer regions. USAID also began

the transition, at least not in the same form. All of these factors led to the design of a new and final phase of USAID support in Brazil.



## THE *F*INAL YEARS: A SHIFT IN STRATEGY

In July 1992, USAID designed a new strategy for family planning assistance in Brazil, noting that the overall high contraceptive prevalence rate (66 percent in 1986) masked disturbing realities in the family planning service delivery system. For example, almost 80 percent of all contraceptive users relied on only two methods: female sterilization and oral contraceptives. In the Northeast where sociodemographic disparities were even more pronounced, the use of oral contraceptives was declining while the reliance on female sterilization (and abortion) was growing.

the two northeastern states of Bahia and Ceará by expanding the choice of contraceptive methods, improving counseling, and improving informed choice and method use. In addition, the strategy was designed “to promote the sustainability of family planning in appropriate delivery systems,”<sup>4</sup> recognizing that family planning services needed to be provided within the context of a Brazilian service delivery system that focused broadly on family, women’s, and reproductive health. As a result, USAID focused less on NGOs and instead worked directly with the state

**USAID worked directly with the state health systems in two large northeastern states, Bahia and Ceará, where existing services needed to improve.**

USAID’s new strategy was designed to focus on improving quality to poorly served populations in



health systems in Bahia and Ceará, where existing services needed to improve. Also, for the first time, the strategy placed a high priority on “accessing the resources and network of the private commercial sector and its capacity for service delivery, commodity production, and distribution.”<sup>5</sup>

USAID also clearly stated its intent to phase out program activities over an eight-year period ending in 2000. All USAID-supported programs were to be self-supporting or would need to identify other donor funding by this time. A major concern was whether contraceptive products, provided in large quantities by USAID for decades, would continue to be available at reasonable prices through the public sector or NGOs.

## PROGRAM *A*CHIEVEMENTS

**F**rom 1992 to 2000, a large number of activities took place through the combined efforts of many USAID-supported organizations.

USAID's assistance was concentrated in two of the poorest states: Bahia (12.5 million inhabitants) and Ceará (7 million inhabitants). Activities undertaken with state health authorities in Bahia and Ceará included the following:

- ▶ Strategic planning;
- ▶ Management and leadership training;
- ▶ Pre-service and in-service training of health providers;
- ▶ Contraceptive procurement and logistics monitoring;
- ▶ Behavior change communication; and
- ▶ Situational analyses of service facilities.

In addition to the state-level activities, USAID supported some national private-sector and policy activities. The Appendix contains a list of U.S.-based organizations that carried out the national and state-level activities in cooperation with USAID. The following sections summarize and highlight the major changes resulting from these activities.

### **A Changing Policy Environment**

The policy environment for reproductive health and family planning activities in Brazil has improved substantially since 1992. Prior to that time, the program had experienced more than two decades of disagreement between family planning organizations and women's health and rights activists who viewed donor-supported family planning as "population control." In addition, many Brazilians inside and outside the government resisted foreign involvement in an area con-

sidered to be a sovereignty concern. Although some resistance persisted during the 1990s, the overall climate improved considerably. The government now clearly supports family planning in the context of reproductive health.

The new vision of reproductive health and family planning emerging from the 1994 International Conference on Population and Development (ICPD) contributed significantly to the changed political environment. Brazilian women's groups were major players in the Cairo process and helped forge the client-focused approach that was agreed upon in the ICPD Programme of Action. BEMFAM and other USAID-supported agencies embraced the Cairo process. USAID encouraged dialogue among the family planning and women's organizations, supported their participation in the Cairo conference, and encouraged its cooperating agencies to adopt the principles of the Cairo Programme of Action.

In the years after Cairo, USAID and its counterparts maintained low profiles in the policy arena, while national groups lobbied on the major issues. Brazilian organizations such as the National Commission for Population and Development, the National Women's Reproductive



Health and Rights Network, and the Feminist Center of Studies and Assistance (CFEMEA) took the lead in the development of national policies on population and reproductive health and rights. They successfully lobbied, for example, for legislative action to legalize surgical sterilization and other methods of fertility regulation. These groups continue to play an active advocacy role in legislative and regulatory areas, mobilizing public support for reproductive health and rights, and monitoring and controlling opposition to sexual and reproductive health rights. USAID and its collaborating agencies supported policy efforts by providing technical guidance and training, addressing regulatory obstacles, and conducting operations research.

### Strengthening the Research Base

USAID assistance for research and data collection supported population and reproductive health policy development and program decisions. With USAID support, BEMFAM partnered with the global, USAID-funded Demographic and Health Surveys program to conduct two national surveys (in 1986 and 1996) and a Northeastern Regional Survey in 1991. These surveys contributed enormously to awareness of population and reproductive health issues at all levels. Operations research also helped improve service delivery, test the introduction of new contraceptive methods, and involve local communities in program management. BEMFAM's continued survey work with the Ministry of Health's (MOH) support clearly indicates that technical sustainability was achieved.



### Increasing Contraceptive Method Choice

Given Brazilians' heavy reliance on only two contraceptive methods, USAID undertook efforts to broaden contraceptive choice at the national and state levels. These efforts included the reintroduction of the IUD, introduction of injectable contraceptives, emergency contraception, and the female condom. The Population Council conducted acceptability studies and clinical performance studies for many of these new methods.

USAID's private-sector initiatives contributed to the wide-scale introduction of two three-month injectable contraceptive brands (Depo-Provera and Triciclon) through a contraceptive social marketing initiative, initially through the Social Marketing for Change (SOMARC) project and later through the Commercial Market Strategies project. In addition, a new contraceptive supply company, CEPEO, successfully reintroduced an affordably priced IUD in the Brazilian commercial market—along with other products such as spermicides and diaphragms. In addition, there has been major expansion in the social marketing of more affordable condoms by Digitagle Kommunikations Technik (DKT, a German group) under the HIV/AIDS program and through BEMFAM's launch of the Prosex condom. These two brands now constitute approximately 17 percent of the overall condom market.

Working in collaboration with the MOH and the Brazilian Federation of Societies of Obstetrics and Gynecology, the Population Council conducted a series of workshops on emergency contraception. Shortly after, the MOH officially included the method in the Brazilian Family Planning Norms. As a result, one of the top five pharmaceutical manufacturers and importers in Brazil has registered and introduced an emergency contraceptive product on the commercial market.

All of these efforts have laid the groundwork for expanding the choice of contraceptive methods in Brazil. However, use of the new methods is still low, and, when measuring the contraceptive-use pattern with a population-based sample such as the DHS, changes will only appear gradually, even with new contraceptive choices for nonsterilized women. In addition, there are still substantial barriers to the expanded use of new methods. Providers tend to be biased against

methods that require counseling and follow-up, and they strongly resist the IUD in particular.

## Ensuring Access to Affordable Contraceptive Methods

In its final strategy document, USAID emphasized the need for increased availability of contraceptive commodities in the public and NGO sectors. Oral contraceptives have been largely provided through private pharmacies—approximately 90 percent according to DHS data—so the demand among public and NGO facilities is relatively small. There has been some improvement in public-sector contraceptive procurement: A number of states and some large urban municipalities now purchase their own commodities. The state of Bahia became one of the first to purchase contraceptive commodities in 1997, and then successfully engaged its municipalities in a cost-sharing program in 1999, spending over US\$1.7 million on contracep-

oral contraceptives are now included in the basic medicine package. It is unclear how smaller municipalities will be able to procure contraceptive commodities, other than through BEMFAM contracts or bulk-purchasing agreements. Indeed, many municipalities purchase other medicines at retail rather than wholesale prices. These issues will need to be addressed as decentralization continues.

## Strengthening the Private Sector

The decision to focus program investment in two northeastern states necessarily involved trade-offs, resulting in less of a focus on private commercial investment in family planning than might have been anticipated. USAID's final strategy did, however, tap into the resources and networks of the private commercial sector, using several different approaches. The strategy also hypothesized that if large-scale health maintenance organizations,

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tives. The MOH is launching a major initiative for the national procurement of oral contraceptives, injectables, IUDs, and diaphragms. This national-level procurement is a three-year "transitional" measure ensuring that states and municipalities develop their own capacity to manage contraceptive procurements on a sustained basis. BEMFAM is also now purchasing contraceptive methods on the open market for distribution through approximately 1,100 municipalities—something they were not doing as recently as 1995.

Despite these improvements, the long-term availability of contraceptive commodities through the public sector remains in question. With the decentralization of the health sector, municipalities will eventually be responsible for their own commodity procurement. Although the basic service package financed under the Unified Health System includes family planning in principle, not all municipalities actually spend this money on family planning. In addition, contraceptive methods are not yet included in the basic medicine package available for most municipalities. This may be modified at the state level; for example, in Ceará, combined

third-party insurance, and group medicine plans incorporated family planning, a broader contraceptive method mix would be available to the growing number of middle- and upper-middle-income Brazilians using private insurance plans.

In several areas, collaboration with the commercial private sector produced important results. Examples include the social marketing of injectable contraceptives in collaboration with several multinational pharmaceutical manufacturers; the introduction of a dedicated emergency contraceptive product with one of Brazil's leading importers and distributors of pharmaceutical products; and CEPEO's introduction of affordably-priced IUDs and a range of other methods. Unfortunately, efforts to engage a large health maintenance organization, UNIMED, in including family planning in its benefit package and in expanding access to lower-income beneficiaries proved to be unsuccessful. UNIMED failed to deliver on its commitments and eventually USAID support was withdrawn. Unfortunately, even today, most insurance packages and health maintenance organizations do not include family planning coverage.

## Reinforcing BEMFAM

BEMFAM, an IPPF affiliate, has received continuous financial, technical, and commodity support from USAID since its founding in 1965. In the final years of its program, USAID wanted to ensure the financial and technical sustainability of BEMFAM. After a slow start, BEMFAM is well on the way to achieving this goal. By the end of 2000, BEMFAM will achieve 91 percent self-suffi-

Rio de Janeiro, and has diversified its funding sources and program areas.

BEMFAM's convenios (agreements) program is an important area of its work, providing reproductive health support to municipalities in the northeastern states through contractual agreements. The services include the following:

- ▶ training the municipal health team twice a year;

**“BEMFAM is the salvation of most small municipalities.”**

—senior Ceará health professional

ciency—the revenues generated by the organization will cover almost all of its operating expenses. BEMFAM's sustainability is possible through the combination of many different initiatives. Perhaps foremost, BEMFAM successfully institutionalized a new corporate culture, balancing the organization's social service and financial sustainability objectives.

BEMFAM revamped its social marketing department, and introduction and sales of its Prosex condom have gone extremely well. BEMFAM has improved the profitability and promotion of its clinics and laboratories in Fortaleza, Recife, and

- ▶ monthly supervisory visits to each health post;
- ▶ a monthly supply of a range of methods (oral contraceptives, condoms, diaphragms, IUDs, injectables, and spermicides);
- ▶ training in stock management and record keeping; and
- ▶ free supplies of informational materials on sexual and reproductive health and STD prevention for clients.

In 2000, BEMFAM had convenios with over 1,100 municipalities, representing approximately 2.3 million clients. Even in Bahia where state-sup-



ported family planning services have grown rapidly, BEMFAM reports that it has convenios with over 85 percent of the state’s municipalities.

The future of BEMFAM’s largest program is uncertain. If federal and state governments begin to fulfill their legal responsibilities in reproductive health, then the convenios will become less needed. However, BEMFAM’s contracts provide a valuable service for the municipalities and will likely continue to be in demand, particularly as BEMFAM continues to diversify the services it offers.

### Introducing PROQUALI

In 1995, USAID urged its collaborating agencies to develop a common programmatic effort with the state secretariats of health in Bahia and Ceará to improve the quality of health services. The process led to the pilot introduction of the Quality Improvement Program, or PROQUALI, a client-focused model of service delivery that is designed to improve reproductive health services in public-sector health facilities. The PROQUALI approach was designed to combine the experience of many different quality improvement initiatives, while including elements of accreditation, management training, and promotion. The PROQUALI program represents a collaborative effort of several different USAID collaborating agencies (Management Sciences for Health, and Johns Hopkins University’s



- ▶ performing a set of client-exit interviews regarding quality of care, allowing for complaints and suggestions, and conducting focus groups with clients regarding perceptions of quality of care;
- ▶ developing and implementing an action plan based upon the above feedback;
- ▶ conducting on-site training and technical assistance to improve skills and address the quality issues identified during the baseline assessment;
- ▶ repeating the assessment after agreed-upon improvements have taken place;
- ▶ applying for accreditation as a PROQUALI unit,

**“The change in behavior and services at the health post is almost a miracle.”**

*—senior SESA/Ceará health official, March 2000*

JHPIEGO Corporation and Center for Communication Programs) —an approach that differs from the previous state-level initiatives. These three agencies together implemented the various steps included in the PROQUALI process. These steps include:

- ▶ conducting a baseline assessment of the health facility using standardized quality criteria to identify strengths and weaknesses;
- ▶ performing a self-assessment of the quality of reproductive health and family planning services provided within the facility;
- ▶ implementing a continuous quality improvement process, called TOQUES in Brazil;

to be approved by an outside team once the facility has fulfilled the agreed-upon quality criteria; and

- ▶ conducting an accreditation ceremony for the clinic that includes participation from the local community followed by community-level campaigns to increase awareness and participation.

The facilities that participate in the PROQUALI system benefit from management training, team-building exercises, in-service training of health care staff, physical improvements in the facility (financed by the municipality), reliable provision

of commodities, and access to a wide range of informational materials. The management training has involved leadership development, organization of quality services, handling of commodities and logistics, and reporting and information systems. The in-service training is closely linked to strengthening the technical standards for the provision of reproductive health care, from clinical skills and infection prevention to interpersonal communication.

facility signs and hats. These materials greatly increase the visibility of the PROQUALI system; ensure a consistent, client-oriented message via health facilities and the mass media; and increase client participation in health decisions.

The systematic approach to self-evaluation, client feedback, and external assessment has created a strong sense of ownership and determination among facility-level and municipal-level staff, mobilizing local commitment and resources.

**“Ciente satisfeito, prefeito re-eleito” (“Satisfied client, re-elected mayor”) is a phrase often heard these days in participating municipalities in Bahia and Ceará.**

The PROQUALI program includes a wide range of excellent educational materials. The overall approach is reflected in a well-designed communications strategy and slogan *Mulher é pra se cuidar*, or “women are worth caring for and worth caring for themselves.” The educational materials include provider and client banners, counseling cards, murals, videos, posters, five four-minute radio spots featuring different contraceptive methods, street theatre, T-shirts, hats, and health

Improvements in service delivery have been remarkable. The system is widely supported by local officials, and has also brought much needed delegation of family planning and reproductive health responsibilities to nurses and auxiliary staff. Nursing auxiliaries now provide group education; specially trained auxiliary staff can handle regular return visits for family planning provision. Nurses provide all contraceptive methods (except IUD insertion), prenatal care, and pap smears. Physicians are needed only for complicated cases and for IUD insertion. The approach has resulted in better use of existing resources and increased access to reproductive health information. Interestingly, the PROQUALI model has also influenced service quality in other areas of primary health care, since health care personnel naturally apply their new knowledge and behaviors to other areas of their work.

Despite its success during the introduction phase, the PROQUALI nucleus is still quite small. In Bahia, two health facilities were included in the PROQUALI design and testing phase from September 1996 to September 1998. During the expansion phase, 10 additional facilities were included—for a total of 12 facilities. In Ceará, three health posts were included in the pilot phase and then expanded to include an additional 14 posts—for a total of 17 facilities in 12 municipalities. In Ceará, the PROQUALI model has been expanded to its primary health care system and family health program where quality criteria are being established for adolescent health, prenatal care, STD/ AIDS, hypertension, diabetes, dental



health and immunizations. Both Bahia and Ceará have plans for statewide expansion, and most of the development costs of the PROQUALI model have already been invested and need not be repeated. The operational costs of the program are modest—mostly related to extra staff, training, and travel. Since the infrastructure improvements are covered through municipal budgets, operational costs are likely to continue to be covered through local budgets.

### Logistics Management

Support for logistics management is another major USAID contribution to the programs in Ceará and Bahia. In Bahia, Pathfinder International developed SISMAC, a multipurpose management information system for reproductive health. This automated, Delphi-based software program allows the state health secretariat to receive monthly data on commodity logistics, service provision, and training from the municipalities. The data are used for monitoring, decisionmaking, and planning. In Bahia, the system is currently used only for women’s health programs, but could be easily expanded for broader use. In Ceará, Management Sciences for Health developed a parallel effort with software support from BEMFAM. The system in Ceará was designed to integrate contraceptive logistics management with the State Secretariat of Health’s general pharmaceutical logistics system. At the national



in 1998 and received applications from more than 400 state and municipal level health staff. USAID provided financial support to design the initial leadership development training program and cover the costs of the first 100 participants.

## The facilities that participate in the PROQUALI system benefit from management training, team building, exercises, and in-service training of health care staff.

level, the MOH has requested that Pathfinder adapt the SISMAC program to assist them in monitoring commodity flows and service provision between federal, state, and municipal levels.

### Leadership Development

USAID also supported the design and initial implementation of an innovative leadership development program—now entirely sustainable—for the Ceará State Secretariat of Health. The program’s objective was to create a core group of public health leaders for the state. The program started

The training focuses on developing the professional and personal leadership skills of the participants in a public health context. At the end of the initial training, the participants prepare their own professional action plans, which are then periodically reviewed during refresher training provided by the State Secretariat. The State Secretariat is currently planning to expand the program with other donor funds to include additional types of long-distance learning and technology training to improve management performance. The new program will be called LeaderNet.

## REMAINING CHALLENGES

**F**rom 1992 to 2000, a large number of activities took place through the combined efforts of many USAID-supported organizations.

USAID support for reproductive health programs, and particularly family planning, has brought about important changes in the way services are provided in Brazil. Nonetheless, additional improvements are needed at different levels of care (peripheral public facilities, hospitals, and private practitioners) and areas of assistance (service delivery, norms, and teaching of medical students), as well as interventions outside the health sector (e.g., adolescents in and out of school). As health care services continue to decentralize, further support for reproductive health programs is needed to reinforce recent gains. At the university level, major changes are still needed in the basic medical curriculum and in the specialization required for family physicians. In addition, greater collaboration is needed with private health care providers, who have a critical role to play in reproductive health services.

A number of important groups continue to be underserved. During the 1990s, the pregnancy rates among adolescents increased significantly in the two USAID-supported states—and rates have increased in other states as well. The significant increase in adolescent pregnancies raises



the question of how to address the reproductive health needs of this vulnerable group in a more coherent and systematic manner. Although discrete activities reached adolescents, USAID's program did not systematically target adolescents. Additionally, there are still large groups of underserved poor people in both urban and rural areas. The northern states of Brazil face a major challenge in this regard since health care services are unavailable in much larger areas than in Bahia and Ceará. Now that the 1998 Family Planning Law has legalized vasectomy, male-oriented family planning services should be expanded, along with greater attention overall to male involvement in reproductive health.

# LESSONS EARNED

**A** number of lessons emerge from the experiences of the large variety of organizations that worked in Brazil with USAID support from 1992 to 2000.

Many of the lessons highlight the importance of local counterparts investing their own human and financial resources in program activities. To achieve this, local community leaders must be involved in the planning processes from the beginning.

## Program Planning

- ▶ Strategically, the combination of state- and national-level program activities in reproductive health created a synergy, allowing for

ness and sustainability. Requiring local partners to invest their own resources is also important, although their financial limitations must also be considered.

## Evaluation

- ▶ Evaluation systems, including indicators and anticipated results, need to be well-established at the beginning of a program.
- ▶ Local program and policy makers need to be involved in data analysis, despite the fact that the process takes longer, and need to stay involved throughout the program.
- ▶ Evaluation systems must achieve an appropriate balance in the level of information

**Local community leaders must be involved in planning to maximize program appropriateness and sustainability.**

a broader impact than would have been achieved if the USAID program had concentrated all of its resources at either level.

- ▶ Initial program planning takes time and requires a good deal of flexibility. Collaboration among several different agencies became much easier when it was built around a program “idea” such as PROQUALI.
- ▶ During program implementation, it is essential to involve all key partners in evaluating progress and making decisions about program objectives and strategies. USAID’s annual meetings with stakeholders were a valuable tool in this process.
- ▶ Local community leaders must be involved in planning to maximize program appropriate-

required to monitor a program and avoid overburdening local partners with heavy or unrealistic reporting requirements.

## Leadership and Recognition

- ▶ Strong leadership is important to program success. Leadership skills can be taught and strengthened—these skills are not simply “found.” Strengthened leaders can better mobilize resources and can focus attention on technical as well as political issues.
- ▶ Leadership is needed to motivate local staff at all levels throughout the program.
- ▶ External recognition can help motivate local actors. Press and media coverage is valuable in stimulating providers and clients alike.

## Quality

- ▶ The public sector can respond to the need for better quality services if given the appropriate tools. Improving quality can be “infectious” and can have unanticipated results. The process for improving quality tends to motivate the entire health team.

- ▶ Competency-based training at medical schools creates a demand for institutional accreditation and professional certification.

## Sustainability

- ▶ Family planning sustainability requires a change in corporate culture. This involves

## The process for improving quality tends to motivate the entire health team.

- ▶ Quality standards can be defined, implemented, and measured. The development of service norms and guidelines clearly helps to define the function and role of all level of staff.
- ▶ The quality improvement process requires a team approach with strong leadership—community, staff, and clients must be involved. Staff must be able to agree on the concept of service quality.

management, attitude, and behavior changes throughout the organization.

- ▶ The availability of contraceptive supplies is perhaps the single most important issue for sustained services among service delivery organizations. Organizations can and will find a mechanism to substitute methods if given a reasonable time period for transition.
- ▶ The long-term sustainability of donor-funded, public-sector initiatives requires that they be incorporated into existing service delivery systems, such as the State Secretariat’s reproductive health program or the national family health program. This process involves building bridges with state and national program officials who will become important players in seeking future funding to sustain program activities.
- ▶ Sustaining quality depends on continued client demand.

## Training

- ▶ Training must include a long-term investment strategy for the development of local talent.
- ▶ On-site training has proven to be effective in transferring skills and knowledge despite cost issues. If possible, train on site, monitor, and then re-train afterward.
- ▶ Staff rotation for both trainers and trainees is a significant factor in the success of training programs for service providers.

## OPPORTUNITIES FOR GROWTH AND INVESTMENT

**A** number of challenges remain for the organizations that will continue to implement and support Brazilian reproductive health services. The final phase of USAID's program clearly contributed to improvements in the quality of reproductive health services in Brazil, particularly family planning, and produced a number of significant achievements, many of which warrant replication throughout the country. These include:

- ▶ **Expansion of the PROQUALI model.**

Although limited in its current form, the PROQUALI model has been tested and well-received by local counterparts. Officials in Bahia and Ceará, where the model was tested, remain interested in expanding the approach. In order to meet the needs of these two states (even at current facilities), the program will soon require additional support in replenishing stocks of informational materials. Additionally, the neighboring states of Rio Grande do Norte and Sergipe have indicated considerable interest in adopting the program. Because of PROQUALI's easy application to a range of primary health care services, it is relevant in a wide variety of settings.

- ▶ **Support for the SISMAC management and logistics information system.** This integrated system developed to support service delivery in Bahia could be valuable for other state health systems. The MOH has already adopted one element of the system—the logistics management module—for planning and monitoring commodity needs.



- ▶ **Support for BEMFAM's convenios.** BEMFAM's contractual agreements supporting reproductive health delivery systems continue to be in demand and are paid for by municipalities in almost all the northeastern states. BEMFAM convenio services could be extremely valuable in other regions as well, especially the more remote states, but BEMFAM would need an infusion of outside funds to expand the program to new states.
- ▶ **Continuation of surveys and operations research.** Access to reliable reproductive health data has dramatically changed program and policy planning in Brazil over the last decade. To continue advancements in this field, credible data must continue to be available. Although BEMFAM now has the research and analytical experience (i.e., technical sustainability) to conduct these surveys, future surveys will need to be funded on a systematic basis by government agencies or other international donors. In addition, operations research on new and existing contraceptive methods

**A number of lessons emerge from the experiences of the large variety of organizations that worked in Brazil with USAID support from 1992 to 2000.**

will be important for further expanding the method mix in Brazil.

The PROQUALI model, the SISMAC management information system, and BEMFAM's convenios will need additional support to expand the activities beyond their current geographical

limits. Surveys and operations research will require future attention to ensure that they continue. Following the phase-out of USAID assistance in Brazil, additional financial and technical support in all of these areas will help sustain the momentum in reproductive health program and service delivery improvements.

**The final phase of USAID's program produced a number of significant achievements, many of which warrant replication throughout the country.**

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- <sup>3</sup> 1996 Brazil Demographic and Health Survey.
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# A PPENDIX

## Selected USAID Cooperating Agencies Active In Brazil, 1992-2000

### **Deloitte Touche Tohmatsu**

#### **Commercial Market Strategies (CMS) and Promoting Financial Investments and Transfers (PROFIT)**

To increase the use of family planning and other health products and services through commercial strategies

[www.cmsproject.com](http://www.cmsproject.com)

### **Family Health International**

#### **Contraceptive Technology Research Condom Quality Assurance**

To develop and introduce a range of safe, effective, and acceptable contraceptive methods and reproductive health technologies

[www.fhi.org](http://www.fhi.org)

### **The Futures Group International**

#### **Options for Population Policy and Social Marketing for Change (SOMARC)**

To support population policy development, increase resource allocations for family planning, and increase contraceptive use through reliance on commercial channels

[www.tfgi.com](http://www.tfgi.com)

### **International Planned Parenthood Federation Western Hemisphere Region (IPPF/WHR)**

#### **Expansion/Improvement of Family Planning Services in Latin America**

To improve and expand family planning services and assist family planning associations with developing sustainable programs without USAID funding

[www.ippfwhr.org](http://www.ippfwhr.org)

### **Johns Hopkins University Center for Communication Programs**

#### **Population Communication Services (PCS) and Population Information Program (PIP)**

To improve reproductive health through a broad range of information, communication, education, and behavior change programs

[www.jhuccp.org](http://www.jhuccp.org)

### **Johns Hopkins University JHPIEGO Corporation**

#### **Training in Reproductive Health III**

To establish integrated training systems for family planning and reproductive health

[www.jhpiego.jhu.edu](http://www.jhpiego.jhu.edu)

### **Macro International, Inc.**

#### **Demographic and Health Surveys (DHS)**

To improve population, health, and nutrition information through data collection, analysis, and evaluation

[www.measuredhs.com](http://www.measuredhs.com)

### **Management Sciences for Health (MSH)**

#### **Family Planning Management Development (FPMD)**

To help family planning programs develop their capacity to plan and manage sustainable programs

[www.msh.org](http://www.msh.org)

## **University of North Carolina, Carolina Population Center**

### **MEASURE Evaluation Project (and formerly The Evaluation Project)**

To improve program monitoring and evaluation through capacity building and development of evaluation tools and methodologies

[www.cpc.unc.edu](http://www.cpc.unc.edu)

## **University of North Carolina (INTRAH)**

### **Improving the Performance of Primary Providers in Reproductive Health (PRIME)**

To improve the performance of primary providers in family planning and reproductive health

[www.intrah.org/prime](http://www.intrah.org/prime)

## **Pathfinder International**

### **Family Planning Services**

To introduce voluntary and quality family planning and other reproductive health services, and to make existing service systems more effective

[www.pathfind.org](http://www.pathfind.org)

## **The Population Council**

### **The Population Council Program and Reproductive Health Operations Research (FRONTIERS and formerly INOPAL)**

To develop and bring to market new products for family planning and prevention of STDs and to improve service delivery through operations research

[www.popcouncil.org](http://www.popcouncil.org)

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